OVERSIGHT ON VETERANS' ADMINISTRATION'S HEALTH-CARE PROGRAMS AND POLICIES AFFECTING NEEDS OF AGING VETERANS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

ON

OVERSIGHT ON VETERANS' ADMINISTRATION'S EXISTING HEALTH-CARE PROGRAMS AND POLICIES AFFECTING NEEDS OF AGING VETERANS

JUNE 30, 1982

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OVERSIGHT ON VETERANS' ADMINISTRATION'S HEALTH CARE PROGRAMS AND POLICIES AFFECTING NEEDS OF AGING VETERANS

WEDNESDAY, JUNE 30, 1982

U.S. Senate,
Committee on Veterans' Affairs,
Washington, D.C.

The committee met, pursuant to notice, at 10:07 a.m., in room 412, Russell Office Building, Hon. Alan K. Simpson (chairman of the committee) presiding.

Present: Chairman Alan K. Simpson (presiding) and Senator Alan Cranston.

Also present: Thomas Harvey, counsel.

OPENING STATEMENT OF HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman Simpson. Good morning. I welcome you to this hearing. I must say that I feel like an aging veteran myself this morning. I was in New York last night talking to the counsel on foreign relations on immigration. And I went to La Guardia, and they were first going to take us to Baltimore, and then they decided not to go anywhere.

Then we thought we would drive, and then we decided not to. And then I caught the 7 a.m. shuttle. And it was a riotous treat. But your fragmented chairman is here this morning. So welcome to the meeting.

Our purpose today is to conduct oversight on the Veterans' Administration's health care programs and policies which affect the needs of aging veterans, who are eligible for certain VA health care. We will hear from a distinguished agenda of personnel from the VA, Dr. Custis and several specialists on aging and the private sector; the American Legion, the Veterans of Foreign Wars, the Disabled American Veterans, and the AMVETS, about the VA's present capacity and future plans to serve its growing number of aging veterans.

I think that all of us are aware, and increasingly so, of this tremendously large group of World War II veterans who are about to reach the age of 65. This group will raise the number of elderly veterans from the present 3 million to about 8 million in 1995. These veterans will then be eligible within existing VA resources to receive on a nonpriority basis certain VA health care services in VA health centers without being subject to any income or means tests.

I feel that a very basic decision needs to be made on some of the thoughts and questions. How many of this aging population should the VA serve, and in what capacity? At the same time, we must keep in mind cost effectiveness, cutbacks in other social programs, the primary mission of the VA, and the state of current geriatric medicine.

How will the VA be able to handle these expanded number of eligible older veterans, whose health care needs will place an ever greater demand on the entire array of VA health care services? What impact will shifting demographic and geographic patterns have on the VA's plan to meet the needs of aging veterans?

How will changes in medicare and medicaid health care benefits affect the aging veteran's demand on the VA system? Should the large non-service-connected population be made eligible at a more restricted level of benefits? Should the VA be expanded to meet the many health care and social support needs that this aging population will have? How could that best be done, and to what degree should it be done?

They are interesting questions. We hope to start propounding some answers to those questions. I would also note that the committee looks forward to receiving in the very near future the VA's Geriatrics and Gerontology Advisory Committee report, which is mandated by Public Law 96-330.

That report will provide an evaluation of the eight existing VA Geriatric Research, Education, and Clinical Centers, and an assessment of the VA's present and future ability to care for its eligible aging veteran population. The chairman of that group is here with us this morning.

So we are interested today in looking at the current program, and to examine what works, and what does not. The VA's long-term care delivery system appears to be somewhat institutionally oriented. Noninstitutional VA care, personal home care and home based hospital care programs have been implemented only on a limited basis.

We are interested in hearing about the cost effective and quality noninstitutional alternatives to the present system, taking into account sound medical, social, and geriatric findings, and keeping in mind the fiscal constraints that the entire VA as well as the rest of the Government, will continue to experience during the coming years.

So we will want to use the information presented today as part of the basis, in part, for some hard decisions with which the Congress will be faced in these next few years. We need to decide to what extent the VA can effectively treat its veterans during these next two decades.

So we ask each of you today to offer your opinions, your advice, your appraisal of the present VA system and its future direction. Now is the time when we must evaluate how the VA can best continue to provide quality health care to eligible veterans.

Because certainly standing by and doing nothing with the emerging aging veteran population could result in chaotic overcrowding, overbuilding, or even turning away certain members of the veteran population.

So if you would, please, summarize your statement in 5 minutes, in order to allow sufficient time for questions. And, of course, your entire written statement will be placed into the hearing record.

I ask without objection that several written statements on the issue be inserted into the final hearing record. Those statements are from Dr. Eric Pheiffer, director of Sun Coast Gerontology Center in Tampa, Fla.; Jerome Stone of the Alzheimer's Disease and Related Disorders Association; and the American Academy of Ophthalmology.

The committee will submit additional written questions to several of the witnesses. And I would ask that without objection those questions and written responses be inserted into the final hearing record at the appropriate point.

Now let me defer to my good colleague from California, the ranking member of this committee, and a very fine gentleman to work with in the effort of trying to provide programs for the veterans of America. And I thank you, Al.

Senator **Cranston**. Thank you, very much, Al. Good morning to each and all of you. I want to welcome all of the witnesses to today's oversight hearing on issues related to the health care needs of aging veterans. This is a timely and important hearing, and I applaud you, Al, for scheduling it.

It is vitally important that we as a society, and the VA specifically, confront the reality of the so-called graying of our population, and plan ways to meet the challenges it poses—not only in terms of the need for health care, but in virtually all other facets of life.

Because of the concentrated impact of the World War II veteran population—over 12 million strong, and quickly approaching an average age of 65—before the end of the century the VA will face greatly increased health care needs of an aging population.

This is sooner than such a phenomenon will occur on a large scale in other institutions in our society, which will not feel the greatest pressure until the early decades of the next century when the children of the baby boom of the late forties reach age 65.

Although there is much to be done, I think that the VA has taken some steps, such as through the establishment of the GRECC program and nursing home construction, to begin to prepare to meet the health care needs of aging veterans. However, we are nearing a point at which decisions must be made about the agency's future role, not just as a health care provider, but also as a source of research into the process and effects of aging, and as a trainer of health care personnel, and about how the VA's efforts should interrelate with the activities of other entities, including private and other governmental organizations.

As the committee looks into the VA's role of providing health care to aging veterans, there are a number of points that we ought to be clear on, and that I hope that today's witnesses will address. One is the appropriate balance between extended and acute care services to meet the health care needs of an older population.

Although it is clear that there is a greater need for extended care in an older population, it is also clear that there is a greater need in such a population for acute care as well, acute care that is frequently different in type and degree from that needed by a younger population.

Although one approach by the VA to meet the demands of an aging population might be the conversion of acute care beds to extended care beds, that action could create shortages of acute care beds that may be needed for the same population.

Another point is the extent to which many of the needs of such a population, although not strictly medical, do frequently affect the use of medical care resources. Assistance with personal care and other daily living activities to enable the older veteran to be discharged from and remain out of the hospital or nursing home facility can help reduce the utilization of more expensive health care alternatives.

It is also important to focus on the appropriate utilization of the various modalities and levels of care from the standpoints of both cost effectiveness and promoting the older veteran's ability to function independently in the community.

We do no one a favor when we unnecessarily provide total institutional care in a hospital, nursing home, or domiciliary facility when less expensive modalities, such as hospital based home care, day hospital care, or outpatient care would suffice. These modes of care, when used appropriately, are not only less costly, but they can help avoid creating dependence upon an institutional environment.

I believe that the VA, particularly through the GRECC's, can and should be in the forefront of developing forms of health care services that encourage independence and maintain or restore the patient's ability to lead a fuller and more active life in the community.

We also must reexamine the issue of the current law provision which provides eligibility for health care for veterans age 65 and over. When I proposed enactment of that provision in 1970, the information then available showed that virtually all veterans 65 and over were eligible for medicare, and suggested that it was more cost effective for the Government to provide them with needed health care in VA hospitals than to pay for their care in private facilities under medicare.

We need to determine if this situation is changed, and whether the policy represented by the 1970 enactment should be maintained. I note that Dr. Custis has quite properly stressed in his statement this morning that veterans age 65 or over are not eligible under current law for comprehensive health-care services, and do not have a statutory priority for VA care.

It is important to note, both in order to focus the point for any debate on expanding or restricting this eligibility, and also to help insure that older veterans are aware of exactly what they are eligible for and what they can expect.

I regret that I will not be able to remain to hear all of the witnesses this morning. I will, of course, review the transcript carefully, and I intend to submit written questions to today's witnesses. Among the points that I will stress in the questions, and that I hope that some of the witnesses might comment on during the testimony are the following:

The extent of the VA's current efforts, and the priority attached to them, relating to Alzheimer's disease, including research designed to learn more about this terribly debilitating disease, as well as information on approaches to treatment for those afflicted by it.

The need for the maintenance and expansion of the VA's hospital based home care program, which not only frees up hospital beds, but more importantly enables individuals to receive needed care in a highly supportive setting.

How to insure that the many lessons being learned in the various GRECCs are communicated to and utilized by other health care providers and ways in which the VA can involve affiliated medical and other health professional schools to a greater degree in training future health care providers in caring for older patients and in research into the process and effects of aging.

I thank you all for your participation today, and I look forward to reviewing your thoughts and recommendations on these and other issues. I am delighted to see many familiar faces here this morning from the VA. Of course, our fine Chief Medical Director, Don Custis; the Assistant Chief Medical Director for Extended Care, Paul Haber, who has been such a leader in the VA's programs for older veterans; Midge Quandt, the ACMD for Administration; and Jack Westall, who formerly held that position in Central Office, and who recently retired as the Director of the VAMC at Bay Pines, Fla.

I welcome you and all others accompanying you to this hearing. I am glad that you are here. Al, I congratulate you again for pursuing this very important subject matter.

Chairman SIMPSON. Thank you, Al, and thank you for your statement. You certainly have been in the forefront of this particular issue for many, many years indeed.

Without objection, I will submit prepared statements from Senators Strom Thurmond and Frank H. Murkowski to be placed in the hearing record at this point.

[The prepared statements of Hon. Strom Thurmond, a U.S. Senator from the State of South Carolina, and Hon. Frank H. Murkowski, a U.S. Senator from the State of Alaska, follow:]

PREPARED STATEMENT OF HON. STROM THURMOND, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

It is a pleasure to receive testimony concerning problems and challenges which face Congress and the Veterans' Administration in preparing to meet the needs of our aging veteran population. I want to welcome the distinguished list of witnesses who will testify on this important subject today and I look forward to their testimony.

I note from the testimony that the number of veterans over age 65 was 3.3 million in 1981. This number is expected to increase to 7.7 million in 1990 and to 9 million by the year 2000. I believe that all of the witnesses here today agree that we can expect significantly increased demands for health care services as this trend occurs. Already in some areas of the country the demand for extended hospital care exceeds the resources available. This problem, then, is not strictly one of the future. It exists today.

Mr. Chairman, Congress has made veterans who are 65 years or older eligible for certain care without regard to their ability to pay for such care. Their treatment, however, is contingent upon the availability of VA resources which are available at the time of their request for services. Until now, we have done a pretty good job of providing the resource availability required to meet the medical needs of most of those veterans who have requested care. Our ability to continue to provide this level of care, however, is becoming more and more questionable. Certainly, it is time for Congress to explore the options which are available to us in addressing this situation. I am hopeful that today's hearing will provide some of these options, so we can proceed with a policy which will ensure the provision of quality health care to as many of our deserving veterans as possible.

Thank you.

PREPARED STATEMENT OF HON. FRANK H. MURKOWSKI, A U.S. SENATOR FROM THE STATE OF ALASKA

Good morning, Mr. Chairman. I am pleased we have the opportunity to discuss the problems of the aging veteran today.

Most of us are aware of the unsettling statistics showing the large number of elderly veterans who will be exacting an increasing demand on our already overburdened veterans hospitals by the 1990s. I feel that one of the biggest challenges facing Congress and the Veterans Administration is to devise how we can best provide these medical services with the declining Federal revenues that have become a fact of life. Time is running short for us to develop a solution to this growing crisis. Studies of the problem will no longer do; only action will assure that our WWI and WWII veterans receive adequate medical assistance. Therefore, I am pleased that American and Canadian officials recently met to discuss this mutual dilemma.

Last year the nation spent $285 billion on medical care. That is nearly 10% of our GNP and more than what we will spend on defense this year. In addition, the FY 1982 VA budget contained $7.2 billion in medical funds. Therefore, I believe that the importance of assuring cost effective, proper health care for our elderly veterans cannot be overestimated. The neglect of the elderly has been endemic to American medicine for too long.

It is my hope that this hearing will also focus on the issue of hospital-based home care, for this program could save money, cut back on overcrowding in VA nursing homes and hospitals, and improve patient rehabilitation rates and patient morale.

For all these reasons, I greatly appreciate the Chairman's willingness to hold this hearing and his dedication to finding a solution for this problem before our veterans hospitals become dangerously overburdened.

Chairman **Simpson**. So we will proceed now with the hearing and the first panel. Dr. Custis, Don, if you will please introduce your group. I think that might be the best way to do that.

TESTIMONY OF DR. DONALD L. CUSTIS, CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION'S DEPARTMENT OF MEDICINE AND SURGERY, ACCOMPANIED BY DR. PAUL A. L. HABER, ASSISTANT CHIEF MEDICAL DIRECTOR, GERIATRICS AND EXTENDED CARE; DR. JOHN H. MATHER, DIRECTOR, AFFILIATED EDUCATION PROGRAMS SERVICE; FRANK A. MORRONE, DIRECTOR, HEALTH SYSTEMS INFORMATION SERVICES; BARBARA J. PRYOR, SPECIAL ASSISTANT TO THE CHIEF MEDICAL DIRECTOR; AND MARJORIE R. QUANDT, ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION

Dr. **Custis**. Chairman Simpson, Senator Cranston, and members of the staff, we are pleased to be here. In addition to my colleagues that Senator Cranston identified, Ms. Quandt; Dr. Mather is the Director, Affiliated Education Programs Service, Office of Academic Affairs; Dr. Haber; Ms. Barbara Pryor is my Special Assistant, and is also the Staff Assistant to Dr. Busse, the dean of Duke Medical School, who also chairs the Geriatric Committee, and is with us this morning; and Mr. Frank Morrone, Director of our Planning Service and statistician extraordinaire.

Mr. Chairman, I welcome this opportunity to discuss with you Veterans' Administration programs delivering care to older veterans and to consider some of our thoughts about planning for a predictable future in which the number of older veterans is bound to increase. The number of veterans over the age of 65 is said to be 3.3 million in 1981. It is projected to increase to 7.7 million in 1990, and to 9 million in the year 2000.

Expressed as a percentage of the total veteran population, the comparable figures for these same years are 11, 27, and 34 percent, respectively. In 1981 some 798,000 of the 3.3 million veterans over the age of 65 came to the VA for one form of care or another. That represented nearly 25 percent of the group.

It seems to me that the lowest common denominator or prudence requires that we should plan for about 1.8 million of the 7.7 million in 1990, and 2.2 million of the 9 million in the year 2000. I think that the proportion of probably users or would be users of the VA health-care system within the total pool of over 65 years veterans is likely to be somewhat greater than that.

I believe that this is so, because increases in medicare deductibles, and coinsurance, and reductions in medicaid funding will make the VA more economically attractive or even necessary to the future population pool than it was to the 1981 population pool.

We are beginning to experience this problem on a geographically limited basis where cuts in medicaid funding have already produced locally observable increases and demands for care. No one can say exactly at what point by income levels the balance of economic desirability or necessity tilts in the direction of VA care for the user.

But with or without these imponderables, it is clear that a crunch is in prospect. That crunch cannot be met by simplistic, if well intentioned, decrements to the rest of our health-care system. My views on this are based upon professional judgment and a consideration of public policy.

If quality of care is seriously diminished, and if we have less than a completely integrated and comprehensive system, we will have an inoperable system altogether. Let me be more specific. A system that reduces acute care in order to provide other kinds of care needed by an aging population is reducing the kind of care that the aged veteran also needs, needs more than others, and more frequently than others.

A system that reduces this particular kind of care skews the patient population to a point where our affiliations with health professional schools are no longer viable, and thus undermines our major guarantor of quality, and our principal professional recruitment and retention device. If this sounds familiar as an argument, it is. It is the same argument that we have been making against mainstreaming, that by taking away acute care, that would leave us with a system that was no longer viable as a system.

This much, Mr. Chairman, it seems to me sets the context for the overall approach to these problems. My full statement submitted for the record references our many current programs for care of the aged, and some near-term modifications planned for them.

It is our belief that we have already achieved the position of national leadership in both geriatrics and gerontology. In this abbreviated summary, I would like to touch on an item that goes well beyond the VA's plans per se. I should like to put forward what I believe could be a new approach to VA community interaction.

It is based on the evident fact that all the statistics that I have cited to you, confined as they are to veterans as actual and potential patients in our system, may seem to bypass the fact that America itself is "graying".

The issue of an aging population and what means exist or must be created to deal with it creates a set of problems for society as a whole. It seems to me that we must begin to work with communities all over this country in a variety of ways that recognize that we are a part of the problem, albeit a large part, with an estimate that 60 percent of all males over the age of 65 in 1900 will be veterans.

It should follow then that we are only part of the solution. I think that we should on a local basis begin to participate in the creation of structures to deal with overall problems of an aging population, some of whom are veterans, so that we can work together with the communities to get the best bang for both their bucks and ours.

It may be that if we can succeed in starting and nurturing the growth of such VA-community interactive structures, that both the VA facilities and the communities in which they are located could accomplish more with existing and additional resources than each of us is now doing or can anticipate doing alone.

Finally, Mr. Chairman, there is one more statement that I personally would like to register, namely my belief in Robert Nimmo, our Administrator. I know him to be a completely honest individual, genuinely concerned for the welfare of our veteran patients. I have observed him in action through two budget cycles, effectively arguing for resources commensurate with our critical needs. It is not genuinely appreciated, I believe, that the VA budget proposals arriving in Congress would be far more stringent were it not for his persuasive influence. He is understandingly cost conscious, and a dedicated proponent of cost effectiveness, as indeed all of us should be.

The escalating cost of medical care is a national problem, no less critical to the veterans' health-care system than to the private sector of medicine. If the economics of medical care cannot be brought under some better control, it more than anything else will compromise our ability to furnish the level of care our veterans so richly deserve.

Mr. Nimmo is a sensitive and sincere advocate of all veterans, who has repeatedly manifested his conviction that the continued quality and viability of our integrated comprehensive health care delivery system must be protected.

But he is particularly insistent that our plans to meet the coming impact of the aging veteran be realistically based on valid criteria. Were he any less objective, circumspect, and forthright, the Agency and our patients would not be so well served.

I thank you, Mr. Chairman.

Chairman SIMPSON. Thank you, doctor.

I do have some questions for you and any member of your supporting staff. In your personal opinion, what direction do you feel the VA health-care system should take in these next decades in order to balance the health needs of all veterans, and yet respond effectively to the changing needs of these millions of newly elderly eligible veterans?

Dr. CUSTIS. Mr. Chairman, we are currently well into an intensive demographic study of future needs of veterans. I am very pleased with the progress that we are making. Our projections will soon be sharpened as soon as we have available to us veterans' data from the 1980 census. But I am satisfied that our experts in demographic analysis will be able to give us on a fairly accurate basis the percentage of our fair market share in the various categories of care; acute care, extended care, intermediate care.

I feel very optimistic that by this time next year—and with the combined input of our MEDIPP program and the congressionally mandated Geriatric Committee, which has just finished the survey of our GRECC's, and now are embarking upon an overall review of our current capabilities for care of the aged, we will be able to present you with a fairly definitive prospectus that covers the needs of all veterans, and specifically the aged veteran.

Chairman SIMPSON. I certainly will be anticipating that, and I will appreciate having that promptly as it is completed. That will be most helpful.

With respect to nursing home inspections, I wonder if the VA standards are essentially similar to the medicare and medicaid standards. And if so, why is it necessary to conduct separate evaluations at all? Your testimony refers to changes to be made in that area. Would you please elaborate for me?

Dr. CUSTIS. May I defer to Dr. Haber, Mr. Chairman?

Chairman SIMPSON. Please.

Dr. HABER. Mr. Chairman, standards of which you are speaking, I am sure, refer to our Community Contract Nursing Home Care program. The standards are slightly different because our population is generally older than is true in a community nursing home.

It is overwhelmingly male as opposed to a largely female population served by medicare and medicaid. And our patients are in need of and can profit more from certain kinds of rehabilitative efforts. Nonetheless, since the onset of this program in 1965, we have accepted the accreditation of the Joint Commission on the Accreditation of Hospitals with a view to minimizing the need for additional inspections.

Most recently in the last year, we have collapsed the size of our teams, and have made common cause with medicare and medicaid inspections. Thus an individual hospital inspector need not inspect a home that has been accredited by medicare and medicaid unless he so desires, at which point he can mount his own team.

The size of our inspection teams has been collapsed from a multidisciplinary team involving eight or nine people to two people, one nurse and one social worker.

Chairman SIMPSON. What are the differences in economic characteristics and medical needs between patients who are retained in the VA facilities, and those who are placed within the community? Are you able to define that?

Dr. HABER. Yes, sir. The basic criterion—and I assume that you are referring to the differences between VA nursing home patients and community nursing home care patients?

Chairman SIMPSON. That is correct.

Dr. HABER. The basic distinction is not on an economic need, but rather on a medical need. We retain in our nursing homes those patients who require more intensive skilled nursing care than those in the community. And also, those who again can profit more from rehabilitative efforts. Our capacity for rehabilitation, particularly in physical medicine, is greater than that which exists in most community nursing homes.

Economic need plays a smaller role in the placement of patients in that patients who are able to afford care on their own are discharged to the community as a general rule, and their medicare and medicaid eligibility is also taken into account when we make such placements.

Chairman SIMPSON. What is the mix of service connected and non-service-connected patients placed in community facilities compared with patients retained in VA facilities?

Dr. HABER. Patients who are placed in VA facilities who are service connected is about 30 percent. It exceeds that in the community nursing home. The reason for this is that in placing a veteran in a community nursing home, there is a statutory limit of 6 months placed upon the veteran. That limit does not apply to service-connected veterans.

That means that as the years go by, more and more service-connected veterans are offered the opportunity of community nursing home care placement. Since our total census is limited by a congressional allowance in dollars, as time goes on, more and more of those slots are taken up by service-connected veterans.

Chairman **Simpson**. What portion of patients retained in VA facilities would qualify for medicaid, how do you obtain those figures, or how would you know?

Dr. **Haber**. I cannot answer the first question, sir. We would have to supply that for the record. And the way that we would know this is through the interviews of the Social Work Service and the Medical Administration Service in developing the patient's ability to pay for the cost of care or inability.

Chairman **Simpson**. If you would furnish that, I would appreciate it.

Dr. **Haber**. Yes, sir.

Chairman **Simpson** You speak of the 6-month limitation. I am sure that causes you a great deal of staff time to answer those type of inquiries, does it not? For example, why is my veteran spouse eligible for only a commitment for 6 months when there is nothing that I can do with him or her? Tell me about that.

Dr. **Haber**. That is a two-edged sword. On the one hand, it does impose a hardship on an individual veteran and his family. On the other hand, for a given number of dollars, in order to spend those wisely in the community nursing home, one must pay some attention to dividing those dollars up among the largest number of veterans.

And unless the programmatic resources were increased commensurately, every time we placed a veteran in a nursing home and kept him there for more than 6 months, that would deny another veteran the opportunity of also benefiting from community nursing home placement.

So unless the total resources are increased, and we are advocating that, the net result of increasing the length of stay indefinitely would be to deprive other veterans of that potential benefit.

Chairman **Simpson**. How frequently are those patients transferred back to VA facilities at the expiration of the 6 month period?

Dr. **Haber**. Frequently, sir. During the first 6 months, our estimate is that about 50 percent of those patients require intermittent hospitalization. One of the great boons of the VA community nursing home care program is that the nursing home is cast adrift to care for the patient, but we in effect support the nursing home by sending our social workers and nurses occasionally to the nursing home to follow up the individual patient.

In this respect, we differ from medicare and medicaid. We are concerned with the individual, not only the setting. And if the veteran should require hospitalization, our facilities can take him back with no questions asked. This is viewed by the staff, the family, and the veteran with great comfort, because they know that the full panoply of our facilities acute care resources stands behind our nursing home care placements.

Chairman **Simpson**. All right.

Dr. **Custis**. If I might just add something there.

Chairman **Simpson**. Yes, please, Doctor.

Dr. **Custis**. Although the term is hospital based home care, our hospital based home care program also receives patients from nursing homes, who with the rehabilitative effort that is given to them in the nursing homes, are able to be cared for at home, and more comfortably, than remaining in a nursing home.

Chairman SIMPSON. How frequently are non-service-connected patients again placed in community nursing homes after a period of hospitalization which then would give them 6 more months of eligibility for nursing home care?

Dr. HABER. I cannot give you an exact figure, but I know that it is a frequent occurrence.

Chairman SIMPSON. Frequent?

Dr. HABER. Yes, sir.

Chairman SIMPSON. How frequent?

Dr. HABER. I cannot give you the exact figure. I would have to supply that for the record.

Chairman SIMPSON. Would you like to guess?

Dr. HABER. I would say something less than half.

Chairman SIMPSON. If you would furnish that to the committee, I would be very appreciative. I would be very interested to see those figures.

Dr. HABER. Yes, sir.

[Subsequently, the Veterans' Administration submitted the following information:]

During the first 6 months of fiscal year 1982, approximately 23 percent of the patients treated in community nursing homes were returned to VA Medical Centers because they required hospital care. If their hospital stay was less than 15 days, they were returned to the nursing home on the same contract. We conducted a telephone survey on July 15-16, 1982, of 28 medical centers which were randomly chosen, one from each medical district, to determine how many non-service-connected patients were returned to the hospital after a 6-month placement for the purpose of replacing the patient on a new 6-month contract. Less than 1 percent of the non-service-connected patients were returned to the hospital for this purpose. The survey also found that less than 2 percent of the non-service-connected patients were granted extensions beyond the 6-month limitation without returning to the hospital.

Dr. HABER. Actually, our whole philosophy of nursing home placement—and this program, Mr. Chairman, antedates medicare and medicaid by 1 year. So we were in a sense experimental—what we tried to do was to give the veteran, and the congressional law was based on that philosophy, a chance for a transition to another facility, knowing full well that some veterans would require more than that.

If he is rehospitalized for a period of time during his first 6 months, we would then assume that a new period of VA sponsored nursing home care may be authorized by virtue of the fact that a new illness has caused his hospitalization and subsequent nursing home care placement.

Chairman SIMPSON. Well, if you will furnish those, that will be helpful.

The VA seems to place a great emphasis upon its treatment of elderly veterans within institutions. Is that in any sense true because the budget for individual VA facilities is often driven along by the number of occupied beds within a facility?

Dr. CUSTIS. Mr. Chairman, I think it is a historical fact that the bed census in the VA was a very strong determinant in the resources received. That is no longer true. We place great effort and, on occasion, pressure in shortening our length of stay. We do, however, have, unlike the private sector, a sizable number of veterans who have no potential for being cared for at home. They are much too heavy a nursing problem for care in a nursing home environment. And they are more or less permanent or semipermanent hospital cases.

Those long-term bed occupancies are not related to an ulterior motive of gaining more resources. It is an answer to a medical need. Ms. Quandt may have something to add to that.

Ms. QUANDT. No, that fully explains it.

Chairman SIMPSON. I remember that you were here before, Ms. Quandt, at a hearing several weeks ago where there was discussion about whether resource allocation is based upon the number of beds. And we were talking about outpatient and inpatient care. It was not quite as clearly repudiated as you have just done. So there must be some lingering vestige of it perhaps somewhere.

Dr. CUSTIS. I am sure that there is, Mr. Chairman, but I would not care to surface it at this time.

Chairman SIMPSON. I thought not. Let's just say that it may be there. Would that be true?

Dr. CUSTIS. I am sure that that is true.

Chairman SIMPSON. I am sure it is.

So if we say, though, as a given that the budget is no longer driven by the number of occupied beds, and we will say that, what incentives are there in a system that encourages an effective referral to alternate care modes, community home based living arrangements, and others? What are those incentives?

Dr. CUSTIS. I suppose that the main incentive, Mr. Chairman, is the satisfaction of a job well done, and matching what is happening in the private sector in terms of productivity. We hope, however, and I was thinking that Ms. Quandt might pick up on this very issue as a result of the last question, that with our strategic management plan that is now being validated in Ms. Quandt's office that we will have a much more valid set of criteria for resource distribution, and that we will be able to build into that a monetary incentive that awards productivity.

Ms. Quandt, again, will you take advantage of the situation?

Chairman SIMPSON. You better get in.

Ms. QUANDT. Now that I am organized.

Chairman SIMPSON. Yes.

Ms. QUANDT. We are doing two things that will assist Dr. Custis in his MEDIPP plan, which comes out to be a total strategic management process for the Department. We are attempting to establish staffing guidelines for the entire 188,000 employees in the Department of Medicine and Surgery. That means that we will establish staffing standards by level of care; meaning acute, intermediate, chronic, outpatient, and across the whole gamut of a comprehensive program.

We already know that it takes as much nursing staff to operate an intermediate care unit as it does to operate a medical intensive care unit. And that fact is lost on most people. It takes the same amount of staff to take care of a "level one" nursing home case, and that is a bedridden nursing home patient, as it does to care for someone in a cardiac coronary care unit.

Those factors will be put together for a staffing profile of the needs of the Department of Medicine and Surgery, and it will be matched to the resource allocation system, which I discussed in the June 11 briefing. That study is based on the pace of care in a facility, which will in effect provide dollars to the facility that is most cost effectively using the level of care.

In other words, it is not economic to keep someone in a bed if you can treat the person in the outpatient area or the community nursing home at a lesser cost. That is what we are engaged in, and will be referred to the Chief Medical Director for adoption later this summer, with implementation hopefully throughout the system in fiscal 1984. We will use fiscal 1983 to fine-tune what our findings have been.

Chairman **Simpson**. Hospital based home care, I am advised, is provided at 30 VA hospitals. But the program has not been expanded since 1974.

Why has the VA not supported the expansion of the hospital based home care program? And then please tell me how that is funded. If it is expanded, is that going to force cutbacks in inpatient or outpatient care at a local veterans' medical center?

Dr. **Custis**. If I may start the anwer to that question, Mr. Chairman, and again then defer to Dr. Haber. Each year in the budget process, and particularly so during the "ZBB" days, hospital based home care was proposed for expansion only to be lost in the budget process to what was considered to be higher priority program enhancements.

There was also the restraining influence perhaps that the teams, 30 in number, were set up as prototype experiments, and that evaluation of the cost effectiveness of this mode of care had not been done. In the last 2 years, however, we have become more and more satisfied and enthused about what hospital based home care can do for our veteran patients. And we hope that we will be in a position to expand this program throughout the system in the next couple of years.

Just one more observation. With the heavy demand on the system, and the dilemma of decreasing resources to satisfy that demand, it will perhaps skew what hospital based home care can do in terms of reducing census. This is because, consistent with law, we are turning away at the point of access the low priority, nonservice connected would be patient, for lack of resources to handle him.

So it is not going to be easy to have an absolutely valid evaluation of what hospital based home care will do in terms of its impact on census.

Dr. **Haber**. We are very gratified with the program at 30 hospitals. It has not been expanded. There have been higher priorities. We feel that it offers a cost effective way of treating veterans in a more acceptable environment. It is not intended for all veterans.

It can only be used where the veteran lives within a reasonable distance of the VA hospital, so we do not have to spend a great deal of time and money transporting professionals. And he must have a stable environment in his home and a caregiver. We think that the program should be expanded, but only in concert with the initiatives that the Department needs.

I would say, also, that Dr. Custis has pointed out to us that 20 percent of our patients in this program are patients with a terminal disease, usually a malignancy. So in effect it offers us the opportunity to provide a hospice type care program for many patients, who otherwise would not be able to profit from it.

Chairman **Simpson**. And how extensive is that hospice program?

Dr. **Haber**. There are 47 of our hospitals engaged in hospice or hospice like activities, including 30 of them that have this hospital based home care program.

Chairman **Simpson**. For the terminally ill?

Dr. **Haber**. Yes, sir.

Chairman **Simpson**. And are families involved in that, too?

Dr. **Haber**. Indeed they are. We make great efforts to counsel the families, and to have them able to profit from the supports that the VA team can give them. We feel that it is a very unusual activity for an institutional based creature like the VA to be involved in. And we think that it represents a very forward step in our treatment and care.

Chairman **Simpson**. It certainly has proven to be a very remarkable caring activity, indeed, for not only the terminally ill patient, but the family. And I commend you for that activity. Just a few additional questions.

On domiciliary care and residential care homes, how will the VA's reassessment of the domiciliary program affect certain medical care currently being provided, such as psychological or psychiatric treatment, and active medical and physical therapy?

Dr. **Haber**. Sir, the patients who are in our domiciliary are eligible for and in fact receive all of the elements of care that are provided in our hospital settings. So that patients with alcoholism would profit from exposure to an alcohol abuse treatment program. Psychiatric patients would get the benefit of a mental hygiene clinic or followup care provided by our psychiatric staffs.

The residential care program, which you refer to, is devoted mainly to patients from psychiatric hospitals. Ninety percent of those are patients who have been hospitalized, but who cannot return to the community unaided. We extend to the veteran at his own expense the option of going to a residential care setting in which the family acts as a sponsor, and we continue to follow the veteran. It is a very cost effective program, I would say.

Chairman **Simpson**. If you could just briefly comment on problems relating to alcohol abuse and domiciliary residence. We are advised that sometimes those veterans, because of lessened activity and no restriction in ability to fund their activities, are a problem.

Do you find alcohol abuse a significant factor with domiciliary residents?

Dr. **Haber**. Yes, sir. I think that the patients in domiciliaries do suffer from a fair degree of alcoholism. Some estimates have made it as high as 33 percent. That does not necessarily distinguish them from their male colleagues of the same socioeconomic status, however.

I think that we have an effective alcohol treatment program in the VA which centers on outpatient treatment. And the veterans who are domiciled in the VA can profit from these programs as well, involving a multiplicity of therapies: antibuse, adversive conditioning, milieu therapy, the whole gamut of the therapies. In addition, the majority of our domiciliaries have alcoholism programs specifically planned for this population.

Chairman **Simpson**. Will there be any merit in prohibiting the use of alcohol by domiciliary residents as is done by regulations concerning the permanent care residents?

Dr. **Haber**. Alcohol is prohibited in domiciliaries, and has always been. It is illegal to possess alcoholic beverages on a Government facility. On the other hand, there have been a few experiments where alcohol in moderation, beer, for example, is offered to people as a way of enhancing the quality of their life. These are carefully controlled experiments in a few places. To my knowledge, they have proved successful.

Chairman **Simpson**. That would be one Government experiment that there would be volunteers for, would there not?

Dr. **Haber**. Yes, sir.

Chairman **Simpson**. You talk about the alcohol abuse and the care, and that the VA has a good system of support for the alcoholic. And I think that that is important indeed.

To what extent will the VA have, or does it have, plans to meet the treatment needs of the elderly veteran, and again that is what we are addressing today, who may have these chronic alcohol problems in addition to other chronic problems of aging? How are those patients who are already in the system identified?

Dr. **Haber**. Dr. Stuart Baker, who is our coordinator under our Mental Health and Behavioral Sciences Service and the coordinator of the alcoholism treatment programs, and I have developed some statements which the Department of Health and Human Services has put forth on health promotion and disease prevention. You may remember that the Surgeon General has issued a publication.

And they came to us for a statement on what we were doing about alcohol abuse in the elderly. Alcohol is handled differently in the elderly. As a matter of fact, some of our GRECC's, Mr. Chairman, are investigating the permability of membranes in the central nervous system to alcohol.

We feel that alcohol is handled differently metabolically in the aged person than in the younger person. Second, we know that although drug abuse tends not to be a problem associated with the elderly, the aging veterans, alcohol is.

So our plan is to enhance detection, prevention, to look at the root causes of the disability associated with alcoholism. The Veterans' Administration has established through our research service a number of facilities which are specializing in trying to determine the basis for the physiologic differences in the alcohol abusers.

And a number of our hospitals, notably at the Bronx and elsewhere, are looking at the different metabolic pathways that the alcoholic uses.

Chairman **Simpson**. I think that it is very important as you study that, that you get into the picture of the elderly veteran. Maybe they have done that in their younger days, or had problems with alcohol. But I think that the problem of the elderly person who begins to drink excessively because he has losses, and changes, and differences in his life, is worth an extra bit of effort and study to determine.

Because I think that left untreated, that just leads to a greater dependency upon the health care system indeed, and institutionalization, and all of the rest. So I will be very interested in that. That is of great interest to me.

And I have a couple of other questions, and then we will wind up here. The latest census figures show us this massive migration of veterans to the Sun Belt areas of the Nation. And I know that my colleague, Dennis DeConcini, who is a member of this committee, has discussed that with me in detail, as has Lawton Chiles in Florida.

Those three States, and California, have a burgeoning veteran population. Given that veterans indeed are in this major migration, would you expect that would result in an increased demand for VA services in those areas of the United States, and that it would decrease the need for services and support levels for VA services in the other parts of the country, most particularly in the Northeast?

Dr. **Custis**. Mr. Chairman, in anticipation of your question, I have a written answer. You may have noticed the New York Times a week or two ago had an article on this very subject, and it particularly focused on the State of Pennsylvania, and their experience with the migration of the elderly. The article substantiated in a very convincing anecdotal way the gist of this answer which I will read.

On the basis of much evidence that we have now that does not appear to be a likely outcome; namely, that there will be a decreased demand for care of the aged in the North and the Northeast. What we are beginning to see is increased demand for care in facilities in the Sun Belt States. But it is not skewed toward older veterans.

At the same time, demand for older veterans is maintained or increased in the Northeast and the Middle West. In other words, if migration is a matter, as it appears to be, primarily of younger age groups, the oldest, poorest, and sickest may remain in the States where they have lived for a long time, and we might experience a demand that outruns supply in both regions.

Chairman **Simpson**. Well, I thank you, very much. I have some further questions, but I will submit those in writing. One other question on Alzheimer's disease and its care and treatment. What are you finding in the new studies and activities with regard to that particular, newly named phenomenon, which was probably called senility 30 years ago. Is that extraordinary disease increasing in the elderly veteran?

Dr. **Custis**. Mr. Chairman, Dr. Haber has been particularly anxious that he might be able to address that issue.

Chairman **Simpson**. Oh, oh.

Dr. **Haber**. Thank you, Dr. Custis.

Chairman **Simpson**. Well, time is running.

Dr. **Haber**. I will be succinct. It is very important. Some estimates run as high as half the patients in a nursing home are afflicted with some degree of Alzheimer's disease. You are quite right, Mr. Chairman, it used to be called senility. The outlook is much more hopeful now.

The VA is doing two things. One is we are developing a research strategy on how to approach the causes and treatment of Alzheimer's disease. Four of our GRECC's, geriatric research centers, at Bedford, Minn., Seattle, and Sepulveda, are working on it. The Bronx VA Hospital is also very much interested in this, as are other VA hospitals.

A number of possible etiologies are coming to light. We are exploring all of those avenues in the hopes of being able to find out what causes it, and treat it. So much for the future. For the present, we are developing a strategy which will enable all VA hospitals to participate in the care, diagnosis, and treatment of these patients.

In so doing, we have had frequent recourse to the Alzheimer's Disease and Related Disorders Organization, of which Mr. Jeremy Stone is president and will be submitting testimony here. In an endeavor to work with the family, we feel that the Veterans' Administration cannot hospitalize indefinitely all the victims of this disease, but we certainly can do much more than we are doing.

We will be working with the families to help support them and give them an opportunity to work with us in the diagnosis and treatment. We think that this is a very important area, and particularly promising. Because if we can prevent this, we will not have to go on building the nursing homes at the same rate that we are currently contemplating.

Chairman SIMPSON. Thank you, very much. And I thank you for your testimony. Thank you, Dr. Custis, and Dr. Haber, and Ms. Quandt.

[The prepared statement of Dr. Donald L. Custis, Chief Medical Director, Department of Medicine and Surgery, Veterans' Administration, and the Veterans' Administration's responses to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF DR. DONALD L. CUSTIS, CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION

Mr. Chairman and members of the Committee, I welcome this opportunity to discuss with you Veterans Administration programs delivering care to older veterans and to consider some of our thoughts about planning for a predictable future in which the number of older veterans is bound to increase.

I will set the context by citing some statistics of which I am sure all of us are aware, and drawing some conclusions about them to the extent that it is possible to do so on the basis of current knowledge--which is limited.

In other words, I am not absolutely certain of the consequences of these population projections, I do not believe that anyone is or can be certain of them, and I can only propose a prudent way of looking at them.

The number of veterans over age 65 is said to be 3.3 million in 1981, is projected to increase to 7.7 million in 1990 and to 9 million in the year 2000. Expressed as a percentage of the total veteran population, the comparable figures for these same years are 11%, 27%, and 34% respectively.

Let me say, in respect to those numbers, that I am not here to certify some of the more frightening forecasts that have been made. There is an increasing tendency to understand that not all the aged are alone, friendless, ill, poverty-stricken, helpless and without resources. That applies to the population in general and it applies to the aging veterans. Therefore, I do not believe that the VA Department of Medicine and Surgery is going to be overwhelmed on a given day by demands to provide total care of all 9 million veterans over 65 in the year 2000, or all 7.7 million in 1990.

If we should not anticipate the "worst," what should we anticipate? I believe that the best answer we can give now consists of a prudent approach to this not-certainly-known future.

That approach stems from the best currently available data we have about who uses our system. In 1981, some 798,000 of the 3.3 million veterans over age 65 came to the VA for one form of care or another. That represents nearly 25 percent of that group. It seems to me that the lowest common denominator of prudence requires that we should plan for about 1.8 million of the 7.7 million in 1990 and 2.2 million of the 9 million in the year 2000. I say that is the lowest common denominator because no one, surely, has any reason to suppose that there will somehow be a lesser proportion of such populations seeking care at that time.

It is evident that even if we leave the matter there, our system would be experiencing overall demands for care that would exceed our current ideas about adequate resources. But I would not myself leave it there.

I think that the proportion of probable users or would-be users of VA health care system within the total pool of over-65 year veterans is likely to be somewhat greater than that. I believe that this is so because increases in Medicare deductibles and co-insurance and reductions in Medicaid funding will make VA more economically attractive or even necessary to the future population pool than it was to the 1981 population pool. We are beginning to experience this problem, on a geographically limited basis, where cuts in Medicaid funding have already produced locally observable increases in demand for care.

I am unable to say exactly how many more of these users there will be because no one can tell me exactly how and when all the Medicare and Medicaid changes of the future will take place, and no one can say exactly at what point, by income levels, the balance of economic desirability or necessity tilts in the direction of VA care for the user.

With or without these imponderables, it is clear that a "crunch" is in prospect. But that crunch cannot be met by simplistic, if well-intentioned, decrements to the rest of our health care system.

Let me be specific on that point. I mean to say that the problem, to whatever extent it may exist, cannot and should not be solved by any diminution in the quality of care we provide to all our patients, aged or not. And I mean to say also that the problem cannot and should not be solved by any stratagem that reduces the integrated and comprehensive nature of our health care system.

My views on this are based upon professional judgment, and a consideration of public policy. If quality of care is seriously diminished and if we have less than a completely integrated and comprehensive system, we will have an inoperable system altogether. Let me be specific here again. A system that reduces acute care in order to provide other kinds of care needed by an aging population, is reducing the kind of care that the aged also need, need more than others and more frequently than others. A system that reduces this particular kind of care, skews the patient population to a point where our affiliations with health professions schools are no longer viable and thus undermines our major guarantor of quality and our principal professional recruitment and retention device. If this sounds familiar as an argument, it is. It is the same argument that we have been making against "mainstreaming" proposals--that by taking away acute care, they would leave us with a system that was no longer viable as a system.

And if that happens, no veterans, whether aged or not, will derive benefit from the outcome. In short, we must not promise or plan to care for the older veteran through any strategy which disadvantages veterans of all ages.

This much, it seems to me, sets the context for the overall approach to these problems. Before setting forth on a statement of current programs for care of the aged veteran and some near-term plans for them, I should like to touch on two specific items. One of them goes well beyond the VA's plans per se and the other has to do with the Geriatric Research, Education and Clinical Centers.

In the first case, I should like to put forward what I believe is a new approach to VA-community interaction. It is based on the evident fact that all the statistics I have cited to you, confined as they are to veterans as actual and potential patients in our system, may seem to bypass the fact that America is "graying." The issue of an aging population and what means exist or must be created to deal with it creates a set of problems for society as a whole.

It seems to me that we must begin to work with communities all over this country in a variety of ways that recognize that we are a part of the problem (albeit a large part, with an estimate that 60% of all males over 65 in 1990 will be veterans.) It should follow then, that we are only a part of the solution. I think we should, on a local basis, begin to participate in the creation of structures to deal with overall problems of an aging population, some of whom are veterans, so that we can work together with the communities to get the best "bang" for both their "bucks" and ours.

We have recently launched, within the Department of Medicine and Surgery, a Medical District Initiated Program Planning (MEDIPP) process which will increasingly rely on planning that comes up to the center from the grass roots. Through this and other means, we want to encourage the growth of such considerations on the local level, the initiation of experiments along these lines and the search for valid interlocutors in the communities where we are located.

It may be, if we can succeed in starting and nurturing the growth of such VA-community interactive structures, that both the VA facilities and the communities in which they are located can accomplish more with existing and additional resources than each of us is now doing or can anticipate doing alone.

In regard to this idea, let me note that I am proposing some experimentation in the area of a new Federalism, one which makes use of our resources and knowledge, the resources and knowledge of other Federal agencies, and the states and communities.

With respect to the GRECCs, about which I will have more to say later, I want to make a few specific statements at this point. As you know, the Geriatrics and Gerontology Advisory Committee has been carrying out its mandate to conduct site visits at existing GRECCs and is now hard at work on its report to the Congress concerning its findings and its recommendations. That work is not yet completed and I have no wish to anticipate the report or preempt any of its possible recommendations.

On the other hand, I have some views that I have formulated independently on the basis of what I know from internal reports and my own observations. The idea of these centers is a good one and some of their accomplishments have much potential for the future.

I believe, though, that if we are going to make the most of them, we should be in a position to direct their operations on a basis that will play to the strengths of the GRECCs, the facilities of which they are a part and the larger professional community where those facilities are located.

I mentioned earlier the launching of the MEDIPP grass roots planning effort. When that was started, I told our directors that I believed that there exists at each of our facilities what I called a "genius of place." I meant that local knowledge and wisdom, local resources and needs, combined to make a unique approach to planning that a Central Office could never have and should never frustrate. In a different context, the same should be true of the operation and evolution of GRECCs. We must recognize the "genius of place" in our GRECCs and be in a position to make of them all that we can.

In order to make that happen, I am convinced that we must be granted more flexibility in management of these centers. In their current, somewhat rigidly defined state, they are most effective in research and in education, neither of which is unimportant to us, and less effective in affecting the delivery of care, which is no less important to us. I believe we are launched upon a good and productive course with the GRECCs and what we need is enough leeway and resources to follow through on that course.

Medical Eligibility for Older Veterans

I shall now turn to some statements about the eligibility of the older veteran population and VA's care programs for it.

There appears to be a belief that older veterans have been given "special" statutory entitlement to VA medical care. In fact, the law does not impose an "inability to defray" requirement on veterans 65 years of age or older in connection with eligibility for VA medical care (38 USC 610(a) (6)).

However, in the absence of some additional statutory entitlement, such as need for care for a service-connected disability, these veterans are not entitled "carte blanche" to care from the VA system. Age alone grants no priority to older veterans over other nonservice-connected veterans. However, medical need criteria must be met for acceptance of older veterans, as it must for all other veterans. Older veteran beneficiaries who claim travel benefits must meet the existing means test--a "poverty oath" of its own--the same as all other veterans without "special" statutory entitlement. Also, older veterans have no special eligibility for contraft medical care funded by VA.

Of the 3.3 million veterans we mentioned earlier as the 1981 population pool, 400,000 were service-connected, and 440,000 were VA pensioners. About 100,000 pensioners were receiving an additional allowance for aid and attendance (or housebound benefits.)

As you are well aware, we have for some time been engaged in the painful and slow moving task of "going behind the poverty oath" for under-65-year-old nonservice-connected veterans. That task has still not been completed.

Hospital Care

As has already been made clear, the aging veteran does not cease to require acute hospital care. It is important to remember that this need does not occur along a certain continuum in which a patient receives acute care once and never again.

Perhaps as a way of gauging the potential buildup of demand for hospital care for the aging veteran, it has been estimated that by 1990, 50% of all beds in VA hospitals will be occupied by those 65 years old or older.

We also provide extended hospital care (or intermediate care) within our hospitals when acute care is no longer necessary for a given patient. The aging factor is important here. For example, while we project that about 27% of patients in VA hospital beds in 1983 will be 65 or older, about 50% of those receiving intermediate care will be in that age bracket. This intermediate care program provides care to patients who need long-term physician involvement and hospital-based support services. The present number of beds in this program is about 10,000 (10,557). This program serves patients who are not yet medically stabilized and who could not be treated in nursing homes.

In addition to our own hospital care, the VA will assist six States to provide hospital care in seven State Homes to 3,569 veteran patients (590 ADC) in FY 1983. Of those to be provided such care, approximately 71% are expected to be age 65 or older.

Extended Care

The VA's Extended Care programs now encompass a broad spectrum of care for veterans of all ages who need such care and is not a function of care for older veterans per se. The range of programs, in addition to the extended hospital care, or intermediate care already described, includes: Nursing Home Care which has three components--the VA's own Nursing Home Care Program; the Community (contract) Nursing Home Care Program, and the State Home Nursing Home Care Program; the Domiciliary Programs of both the VA and the States: Outpatient Care; the Hospital-Based Home Care Programs, many of which incorporate hospice type services; a Residential Care Program; and one prototype Hospice Program caring exclusively for the terminally ill.

This system of extended care has certain characteristics. The majority of patients enter the system from the acute care hospital system and, if they become acutely ill, are transferred back to the acute care hospital system. The programs are arranged in order of decreasing dependency, or to put it another way, in order of increasing rehabilitation. Patients are encouraged to do for themselves and to be involved in decisions about their care. We are concerned with preserving the quality of life of all veterans in the various elements of this extended-care system.

The system calls for balance. In the nursing home care programs, for example, we provide the most intensive care in VA nursing homes. Veterans needing less intensive care, can be transferred to community nursing homes, whether skilled or intermediate care facilities. This program has the advantage of being able to place veterans nearer to their homes and families. We also have the option of transferring patients to State Veterans Home nursing home facilities for extended care. These three nursing home programs give us flexibility and balance. As patient care needs change, we have the ability to transfer patients to a more or less intensive level of care.

The Department recognizes the need to know more about the extended care medical needs of elderly patients. Two demographic studies are underway to sharpen our projection of the need for such services.

In the interim, prior to the MEDIPP submissions in November of this year, the VA is proceeding with the construction of additional VA nursing home beds. Further, in the MEDIPP context, we are also evaluating where it may be feasible to convert existing hospital care beds.

Nursing Home Care

In FY 1983, the VA will operate 101 skilled nursing home care units with a total of 9,515 average operating beds, to provide care to 14,358 veterans (8,974 ADC). Approximately 62% of the veterans receiving this care will be age 65 or older. During the next five years, approximately 3-4,000 additional beds are projected. Utilization of this program by aged veterans is expected to continue to increase.

Both skilled and intermediate nursing home care will be provided by the Community Nursing Home Program to 29,688 patients (9,395 ADC) in FY 1983. About 56% will be age 65 or older. To meet the total projected need for nursing home care during the next five years, particularly for the aging veteran, this program will have to be increased at approximately the same rate as the VA Nursing Home Care Program. The Community Nursing Home Care Program, because of the number of homes available, can provide care closer to the veteran's home and can be quickly responsive to changing needs both nationally and locally.

One complaint has been the proliferation of inspections by Federal and State agencies. The VA has an ongoing project with DHHS and State survey agencies directed toward reduction of duplication of effort in the inspection of nursing homes, and toward the improvement of the quality of care in those homes.

The VA will assist 27 States to provide nursing home care in 41 State Homes to 11,934 veteran patients (6,744 ADC) in FY 1983. Of those to be provided care, approximately 73% are expected to be age

65 or older. A 15% increase in patients treated is expected in this program during the next five years.

Domiciliary Care

The Domiciliary Program calls for the VA to operate 7,778 beds in 16 domiciliaries to provide care to 13,700 patients (7,000 ADC) in 1983. About 30% of those patients will be age 65 or older. Most of the facilities are over 50 years old, and do not meet current standards of fire safety and privacy. It is planned to renovate those facilities, where feasible. There should be 5,851 new or remodeled beds available by the end of the planning period.

Replacement domiciliary facilities were completed and activated in Fiscal Years 1980 and 1981 at the VA Medical Centers in Wood, Wisconsin; Martinsburg, West Virginia; Dayton, Ohio; and Bay Pines, Florida. These facilities were designed at a time when the policy was to construct domiciliaries with the capacity for immediate conversion to nursing homes.

I must say that a good deal of thought had gone into the question of the domiciliary program. A comprehensive reassessment of the domiciliary program has been completed and we have a new approach to what its mission ought to be.

It will be a program for veterans who have a physical or mental impairment requiring access to continuing care or rehabilitation, but whose condition is such that the regular daily care and services provided by a hospital or nursing home care is not required. We are going to be working with the Associate Deputy Administrator for Construction to develop plans for assuring that all facilities to be used for this program are safe, provide adequate privacy and comfort, and are located in such a way as to provide ready access to a hospital or clinic from which medical care can be supervised and to which the patient may be readily referred if a higher level of care is necessary.

In addition to our own domiciliaries, we will assist 32 States to provide domiciliary care in 43 State Homes to 9,550 veteran patients (4,856 ADC) in FY 1983. Of those to be provided care, approximately 51% are expected to be age 65 or older. A 17% increase in patients treated is expected in this program during the next five years.

Grants for Construction of State Extended Care Facilities

This program assists States to construct new State Home facilities as noted above, for furnishing domiciliary or nursing home care and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home, or hospital care to veterans in State Homes so that life-safety and other deficiencies identified by the VA and the State can be corrected.

Applications on hand total more than $81 million (VA share) and States have estimated they will submit additional applications of more than $120 million future years. This program is funded at $15.8 million in Fiscal Year 1982.

Outpatient Care

In addition to all these institutional programs, there are several programs designed as alternatives for institutional care. In FY 1983, VA facilities will provide almost 16 million outpatient visits, 157,000 dental exams, and 156,000 dental treatments.

About 19% of the outpatient visits will be provided to veterans age 65 or older, but the projected increase for this age group will be substantial, at 62.3%. Outpatient care is also provided in non-VA facilities. Of the 1.9 million medical fee visits, approximately 22% will be by veterans age 65 or older.

Hospital-Based Home Care, Geriatric Day Care, Residential Care Home

Another non-institutional program, the Hospital-Based Home Care Program, is currently operating in 30 VA medical centers. This program provides medical services through 145,000 visits annually (1681 ADC) to homebound patients who otherwise would require institutional care. Another alternative which may facilitate home care is the establishment of geriatric day care centers. The VA is exploring the feasibility of these programs. These would provide "day hospital" capability which assists the patients and enable them to carry on rather than being pladed in an institution.

The Residential Care Home program provides health care supervision to veterans who do not require hospital or nursing care but who, because of medical or psychosocial health conditions, are not able to live independently and have no suitable family resources to provide the needed supervision and supportive care. The veteran must be essentially capable of performing activities of daily living with minimal assistance. Food, shelter, care, and supervision are financed with the veteran's own resources (often derived from VA compensation or pension) in residential settings inspected and approved by the VA, but chosen by the veteran. The veteran receives follow-up visits from VA health care professionals and is an outpatient of the local VA medical center. Thus, the per patient cost of this program is the least expensive of the extended care programs. Originally begun as a program for the post-hospital care of psychiatric patients, the program is now being developed for the care of medical patients. In FY 1983, we expect to have 12,700 patients in residential care homes.

Geriatric Research, Education and Clinical Centers

I have already stated some general views about our GRECCs. As to specifics, the program began in Fiscal Year 1975. Currently, there are eight GRECCs at the following locations: Bedford/Boston, Massachusetts; Little Rock, Arkansas; Los Angeles (Wadsworth), California; Minneapolis, Minnesota; Palo Alto, California; St. Louis, Missouri; Seattle/American Lake, Washington; and Sepulveda, California.

The GRECCs were intended to attract outstanding professionals to teach and to conduct basic and clinical research on aging, to provide education in geriatrics, and to experiment with alternative means for providing care to the aged.

The GRECC concept received increased attention, culminating in Congressional passage of Public Law 96-330, "Veterans Administration Health Care Amendments of 1980." Title III of that law, "Geriatric Research and Care" authorized expansion of the GRECC program up to 15 GRECCs. However, because resources were not forthcoming to make this possible, we have been concentrating on enhancing the extant GRECCs, consistent with the Public Law provisions, rather than on creating new GRECCs.

GRECC activities have been directed towards utilizing existing resources to provide geriatric care and to integrate clinical research and trained health care providers in geriatrics and gerontology into the VA system. As a part of the program, GRECCs have been developing Geriatric Evaluation Units (GEU), usually of 10 to 30 beds, for intensive diagnosis and therapy. Five GRECCs have developed GEUs with a broad base in general internal medicine. GRECCs also provide consultation and conduct geriatric outpatient clinics.

Each Center typically emphasizes one area of research relevant to aging. For example, one has developed a cardiopulmonary function evaluation unit, and four others, all with neuropsychiatric orientation, are focussing on chronic neurological diseases and organic dementias, including Alzheimer's type.

GRECC professionals have produced more than 500 scientific publications since the beginning of the program in FY 1975. GRECCs have reported the award of over $10 million in research funding during the FY 1979-1981 period. About $6 million of this was awarded through the VA merit review process, about $2.4 million in FY 1981 alone. The GRECCs also received awards of approximately $4 million from other Federal agencies and private foundations in the FY 1979-1981 period.

The GRECCs conduct continuing education seminars, workshops, lectures, and other professional and in-service training. Over 30 of the GRECC staff have teaching appointments in academic institutions.

Education and Research

In addition to the GRECC programs, a variety of education and research activities directed at the aging population take place throughout the VA health care system. For example, a Geriatric Physician Fellowship Program was established in July 1978 and by 1982, the program reached full scale with 48 physicians in training, and 24 of those completing training each year. This program is conducted in eight facilities, four of them GRECCs.

To accompany its training for physicians, a program of interdisciplinary team training in geriatrics was initiated in FY 1980. This program includes development and coordination of curriculum components in gerontology at affiliated schools; career development for VA staff; and continuing education for geriatric teams. A Geriatric Dental Program began in 1982 with dental fellows being trained in geriatrics in 5 VA medical centers, two of them having GRECCs. The newly initiated nurse scholarship program has established gerontologic nursing as one of its priority areas. Continuing education efforts are directed at developing staff skills and attitudes necessary for providing quality care to geriatric patients.

In research, there will be emphasis on investigation of special areas of particular importance to the aged, such as diabetes, chronic ischemic heart disease, chronic obstructive lung disease, schizophrenia, and the development of new and improved sensory aids.

This completes my presentation. I shall be pleased to attempt to answer any questions you may have.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. Have you considered the feasibility of operating the community nursing home care program in a manner more similar to Medicare/Medicaid to fully minimize duplicative efforts and to promote equitable patient treatment?

Answer 1. The VA Community Nursing program has, since 1980, used the same standards as those used by the Department of Health and Human Services for the certification of such homes for the Medicare or Medicaid programs. VA Standards for Intermediate Care Facilities are the same as those used for the Medicaid program except that VA has slightly higher nurse staffing standards considered necessary to meet the needs of the veteran population in placement.

Since April of 1981, the VA has "piggybacked" on the inspection required for the certification of nursing homes for the Medicare or Medicaid programs, thus reducing duplication of effort. The VA inspection team has been reduced from six to two members (nurse, and social worker) whose function is to assess quality of care and quality of life in the homes.

Question 2. Why does the VA contract for comprehensive care, (including physician care and medication) at a rate 15% higher than Medicaid pays for the same facility, rather than setting up a payment policy that would pay the Medicaid rate for room, board, and nursing care, and would separately reimburse or provide for medical care and medications?

Answer 2. The VA contracts at an all-inclusive rate for community nursing care since the alternative system of separate billing for each of the approximately 9500 patients in placement would impose excessive administrative costs on the agency. In negotiating contract rates with a nursing home, the Medicaid rate is used as an index to help determine prevailing rates for room, board, and routine nursing care. Since the Medicaid rates are generally not all-inclusive, the VA must pay a higher rate to cover the cost of an all inclusive contract. Fifteen percent is offered as a guideline to establish the cost of the additional services. Actual negotiated rates vary above and below that percentage. Strict adherence to Medicaid rates would be counter productive to the program's operation since in some parts of the country Medicaid rates are so low that many nursing homes will not accept Medicaid patients nor would they accept VA patients at the same rates.

Question 3. I understand that the VA provides nursing home care in 3 settings —VA nursing home care units (VANHC), community nursing homes (CNH), and State veterans' nursing homes. In the past, such care has been provided on a 40-40-20 ratio (40% VANHC, 40% CHNC, and 20% State homes). Is this a desirable mix for the future? Please elaborate.

Answer 3. The 40-40-20 ratio used in the past represents a very general guideline for program mix. The VA nursing home care component in the future is being targeted for between 25-40%. Within these floor and ceiling guidelines, each medical district has the latitude to decide what mix is most appropriate.

Question 4. Has the VA conducted any studies to determine whether this is a cost-effective mix for the provision of nursing home care?

Answer 4. No. The mix is based on experience and, in fact, the share of the load borne by VA operated nursing homes has declined by approximately ten percent in recent years. To do a cost-effectiveness study would be difficult because the distribution of the three types of facilities is uneven across the country among the three programs. Among the three programs the criteria for admission, the patients characteristics, and the fiscal support differ. It is our belief that the flexibility associated with having all three programs available to meet the needs of veterans, rather than the absolute proportions, is most important.

Question 5A. Since there will be a great reliance on community nursing homes in the future, what steps has the VA taken to ensure that sufficient beds will be available?

Answer 5A. The VA must rely on the general market availability of community nursing home beds. The veteran nursing home population is small, relative to the total nursing home population; thus, the VA has little influence on the bed supply. We have, however, had few problems in locating beds over the sixteen years of this program's existence.

Question 5B. Has the VA considered multi-year commitments or contracts with community nursing homes?

Answer 5B. The VA has not considered multi-year commitments or contracts with community nursing homes for the primary reason that the quality of nursing home care is not stable: it can and does frequently change with a change in the administrator or head nurse. We, therefore, wish to retain the option to terminate contracts on an annual basis.

Question 6. What differentiates patients placed in community facilities from those patients retained in VA facilities?

Answer 6. While patients in VA and community facilities both have a need for continuing nursing care and other supportive health care services, admissions are usually made to VA facilities for two main reasons. One is that there is no other placement alternative for a patient when he/she is ready for discharge from the hospital. The second reason is that restorative services required for patients who can benefit from a regimen of intensive rehabilitation are generally not available in the community. When nonservice-connected veterans attain their optimal level of function in VA nursing homes, they are discharged to community facilities. Service-connected veterans who are entitled to receive care in VA nursing homes are given first priority for admission and may remain in the program for as long as care is required.

Question 7. What national studies has the VA conducted to determine whether there are any real differences in levels of care needed or quality of care provided in VA nursing home facilities as compared to community nursing home facilities?

Answer 7. The VA has not conducted any national studies in the recent past. A survey is being planned in Fiscal Year 1983 to compare the needs of veterans in both types of nursing care facilities and to determine if the treatment being provided is appropriate for the level of care required.

Question 8. GAO examined the State Home Program in 1981, and determined that it was a cost-effective alternative for the VA. What steps has the agency taken to encourage expansion of the program?

Answer 8. The VA has requested that the authorizing legislation for construction of State home facilities be extended beyond the expiration date of September 30, 1982. Over the past three years the VA has requested, and Congress has appropriated, increasingly larger amounts for construction grants.

Question 9. What proportion of patients placed in community nursing homes do not qualify for Medicaid or have other resources to pay for care?

Answer 9. This question would appear to relate only to nonservice-connected veterans, since veterans who receive care for their service-connected disabilities are entitled to VA care as long as it is required, and thus, have no need to turn to Medicaid or their own resources to pay for care.

For non-service connected veterans, the purpose of the placement period at VA expense is to allow the veteran sufficient time to make the transition from hospital to community living, or allow the veteran or family the time to marshall resources for continued care, which in most cases, is Medicaid assistance. Placement staff at the VA Medical Center are expected to make a preliminary determination as to the veteran's probable need and eligibility for Medicaid assistance. If it is clear that he will not be eligible for Medicaid and has no resources of his own to pay for care, we believe he should not be placed in the nursing home since he would have to be returned to the hospital at the end of six months, unnecessarily risking the traumatic effects of relocation. Thus, while we do not know the exact number, we believe there are few cases in which veterans placed in nursing homes do not qualify for Medicaid after placement. The number who are not placed because of probable lack of resources for continuing care is unknown.

Question 10. Are there patients being retained in VA facilities and not considered for community placement because of economic circumstances?

Answer 10. In a recent survey, it was found that about a quarter of the patients in VA facilities could be outplaced if suitable resources were available. Among the many barriers to outplacement listed, financial difficulties were listed as at least one barrier in 60% of the cases. The extent to which financial difficulty alone delayed discharge is not known.

Question 11A. Your 1977 document "The Aging Veteran" points out that about 1 out of 5 veterans receiving nursing home care are supported by the VA (in either VA, community or State facilities). The others are receiving care at their own expense, through insurance or Medicaid. Does the VA consider that proportion (1 out of 5) a likely pattern for the future?

Answer 11A. Present plans and projections are based on the assumption that the VA will meet 12-16 percent of the actual needs. The ultimate ability of the VA to meet these needs will be largely dependent on the level of resources provided for VA health care programs.

Question 11B. Are present plans and projections based on an assumption that the VA will meet 20% of the actual needs?

Answer 11B. See answer to 11.A., above.

Question 11C. What facts or projections support the use of such an assumption?

Answer 11C. The one out of five proportion is based on historical data reflecting past growth and development of VA nursing home care programs. More recently, the percentage "market share" has declined, thereby resulting in the use of more realistic planning guidance as indicated in 11.B., above.

Question 12.

What portion of the actual demand for nursing home care for non-service-connected veterans does the VA expect to meet over the next 20 years? Are the portions the same for service-connected as for non-service-connected veterans?

Answer 12.

It is estimated that in 1990 VA will support approxmately 11% of the demand for nursing home care for nonservice-connected veterans, and approximately 36% of the demand for service-connected veterans. Data necessary for making comparable estimates for the year 2000 are not currenty available.

Question 13.

Are service-connected veterans ever denied nursing home care due to lack of space when non-service-connected veterans occupy VA nursing home beds? Is that a time when contract care would be used, or would a non-service-connected veteran be moved out of the VA facility due to his or her lower priority?

Answer 13.

The service-connected veteran is given priority consideration for admission to VA Nursing Home Units. Nonservice-connected veterans occupying VA nursing home beds are not discharged. Care requirements mitigate against discharge. When a service-connected veteran applies, the service-connected veteran is placed on a waiting list in the appropriate priority category for admission. Because of low turnover in VANHCU's due to the condition of nursing home patients, a service-connected veteran can be referred for immediate placement in an available community nursing home. If agreeable to the veteran or his/her representative and VA funds are available, placement is effected.

Question 14.

Has the VA revised its plans for providing nursing home care based on current reductions in Medicare/Medicaid benefits or if Medicaid becomes federally administered?

Answer 14.

Recent events affecting the Medicare/Medicaid programs have not been incorporated into VA's plans for providing Nursing Home Care. Future updates of this plan, however, will incorporate such occurrences as more experience is collected on them.

Question 15.

At the time of the "The Aging Veteran" study, the VA pointed out that 54% of nursing home care for the elderly was subsidized through the agency, Medicare, and Medicaid. What would be the effect on VA nursing home care if there are significant reductions or limits on the growth of Medicaid expenditures for nursing home care?

Answer 15.

If limits are placed on the growth of Medicaid expenditures, it is possible that our projection of total veteran need for the future may be understated. We will closely monitor any such changes.

Question 16. How many veterans are aware that they have the option of turning to the VA for nursing home care? What would be the likely effect on demand if that awareness grows?

Answer 16. The number of veterans who are aware that the VA provides nursing home care is not known. It can be assumed that most of the veterans who have entered the VA system of care at any level have this knowledge. However, information about this benefit is directed to all veterans through periodic advertisements in the media and in various VA publications that are disseminated to veterans' service organizations, VA clinics and regional offices. In addition, the Catalogue of Federal Domestic Assistance contains information about nursing home benefits for veterans and this information is updated annually. Estimates from the demographics study that was conducted in 1981 show that by 1990 there will be a threefold increase over previous estimates in the number of veterans who will require nursing home care. It is expected that as more veterans learn about the VA nursing home options the demands for care will increase.

Question 17. How many nursing home beds does the agency plan to have in VA facilities in 1985, 1990, 1995, 2000?

Answer 17. The number of nursing home beds the agency will be requiring in VA owned and operated facilities in the future will be based upon decisions emanating from the Medical District Initiated Program Planning process. The plans due in Central Office in November will contain projections of total need for nursing home care, the share of the market which is believed to be the VA's responsibility, and the required mix of VA, community, and state resources. The district planners have been told to use a market share (the proportion of total veteran needs which will be VA's responsibility) of between 12 and 16%. Further, they have also been instructed to accommodate approximately 25 to 40% of this responsibility in VA-owned and operated facilities. Exactly what number of beds this will result in is not known precisely at this time; however, it is expected that it will range between 13,100 and 25,000 beds. These are projections for the year 1990. More than likely this market share will be held to the year 2000.

Question 18. VA guidelines indicate that rates negotiated for skilled nursing home care should be about 15% higher than the rate Medicaid pays for skilled nursing care in that nursing home, and that the rate for intermediate care should be 10% less than the rate that VA hospital pays for skilled nursing care. Is the VA finding it easier to obtain contracts for intermediate care than for skilled nursing care? If so, why?

Answer 18. No. The VA has had no significant difficulties in contracting for either skilled or intermediate nursing home care. The actual distribution of community nursing home contracts by level of care in March 1982 was as follows:

Skilled	Intermediate	Combined
36%	22%	42%

Question 19. Do the VA's contract nursing homes believe that they get a "better deal" at rates paid for intermediate care than for skilled nursing care?

Answer 19. The VA's contract rates for both Intermediate and Skilled nursing care are negotiated, based on prevailing market rates for such care. Medicaid rates are commonly used as an index to prevailing market rates for both levels of care. The legislation authorizing intermediate care specifies that it must be reimbursed at a rate "commensurately less" than that paid for skilled care. The 10% differential is an internal mechanism to place a cap on intermediate rates. The actual differential as of March 31, 1982 was approximately 14%. We have no indication that nursing home management finds our intermediate care rates are a "better deal" than our skilled rates.

Question 20. Why should the rates paid for skilled care and intermediate care differ by only 10%?

Answer 20. Public Law 94-581 specified that the rate of reimbursement for intermediate nursing care should be "commensurately less than that provided for [skilled] nursing home care..." In developing internal controls to carry out the requirements of the law, the VA surveyed the nursing home market to determine the actual differences in skilled and intermediate nursing care rates. The differential was found to vary widely, in some instances as much as 30% lower, and in a few instances as much as 10% higher. The ten percent minimum was established as a rate within which the VA could operate a viable contract program which would include intermediate facilities of good quality. The actual average differential was 14% as of March 1982.

Question 21. Why is the rate computed for intermediate care not the same as for skilled care (Medicaid + 15%)?

Answer 21. VA medical centers are expected to use the same principles in negotiating for both skilled and intermediate care rates. Neither are actually tied to Medicaid rates. However, in both cases, VA medical centers are encouraged to use the Medicaid rate as an index to the market rates for the two levels of care. VA rates are all inclusive and Medicaid rates are not. The 15% differential is offered to field stations as a guideline in determining the all inclusive rates. Actual negotiated rates vary above and below this percentage.

Question 22A. Were the budgets of individual VA facilities ever "driven" by bed occupancy?

Answer 22A. If one equates bed occupancy with census the answer is yes.

Question 22B. If so, what caused this policy to be changed, when did this change occur, and what specific evidence or guideline indicate this change in policy?

Answer 22B. For many years the Department's budget was wholly determined by census or occupancy levels. For medicine in the 40's and 50's and the VA in the same period, this was not wholly inappropriate: length of stay was long, medical technology was limited, and the difference in cost between acute and extended care was not great. As an extreme example, census is an excellent measure of workload and, therefore, budget for a nursing home or domiciliary. Progressively over the past 25 years there have been major and accelerating changes in each of these factors and, with these changes, census and occupancy rates became less and less adequate as the sole measure of workload and therefore budgetary requirements. Currently census along with patients treated, outpatient visits and staffing ratios are used to determine resource requirements.

Question 23. What studies has the VA made or planned concerning the need and demand for home care among aging veterans?

Answer 23. In 1977, Circular 10-77-21 was issued inviting proposals for the Hospital Based Home Care Program; 48 responses were received. Included in each proposal was a needs assessment based on the veteran population age 60 years and older and the chronic illness and disabilities of this population group within a prescribed geographical area. The issue of the demand for home care services among aging veterans will again be addressed by the Medical Centers through the MEDIPP process.

Question 24. Since the VA is basically a closed, direct care system, do you believe that it is an appropriate setting for a determination of the cost effectiveness of home care for management of chronic problems?

Answer 24. Yes, the VA is uniquely suited for such a study as the HBHC Program was designed for patients with chronic diseases. HBHC data indicate that over the past six years admissions to the program have overwhelmingly been of patients with long term problems such as heart disease, strokes, chronic obstructive pulmonary disease, rheumatoid arthritis and diabetes mellitus. The VA is able to determine home care costs, unlike Medicare which is able to determine charges incurred. Because the VA is a direct care system, randomized studies can be implemented with greater ease and control. Data collection can be done concurrent to the patient's episode of care rather than retrospectively through clinical record reviews. In the VA's HBHC Program, patient information is uniform, standardized and systematically collected.

Question 25. Are you aware of any studies or information that determines the cost effectiveness of alternative community based non-institutional care for the aging? Are there any "hard figures" that compare these costs with more traditional institutionalized care?

Answer 25. Studies on home health services yield inconsistent results with respect to cost and cost effectiveness. Most of the studies on cost savings are the results of the application of selected criteria to existing program data by home health agencies, HCFA demonstration projects, or Blue Cross. Findings are usually presented in hospital days saved or in dollar amounts saved. Typically the figures are determined by a health professional estimating the number of days the patient would have remained in an institution had home health services not been available. The one study which was conducted with scientific rigor was done at the University of Minnesota by Anderson, Patten and Greenberg, and compares the costs of home health with skilled nursing home care and intermediate nursing home care. Cost data were gathered for paid services provided internally by provider organization (home health agency or nursing home), paid services provided by external sources (other agencies), and informal or unpaid services (services provided by family or friends). Their findings indicate that nursing home patients receive more formal service than do home care patients (SNF - 218.5; ICF - 117.2; home care - 38.3 median service hours per month), so that the average monthly cost is substantially higher in nursing homes. There are also two studies presently in progress on this subject being conducted, one in New York State and the other by the University of Colorado.

Question 26. Has the VA conducted any such studies, comparing institutional care with non-institutional care? When I refer to non-institutional care, I mean home health-care services such as part-time skilled nursing care and certain other medically-related services; occupational, physical, and speech therapy; social services -- including adult day care, counseling, financial advice, and transportation; nutritional and health education; homemaker, and personal services -- including cooking, shopping, housekeeping, home maintenance, and feeding.

Answer 26. The VA has not conducted studies comparing care for the elderly in institutional and non-institutional settings. Two such studies have been completed for psychiatric patients, the great majority of whom were not elderly. In one study it was shown that those patients randomly assigned to foster care functioned considerably better than those who continued to be cared for in the hospital. Another study of schizophrenic patients (again, mostly young patients) showed that patients cared for in day centers demonstrated improved social functioning when compared to those cared for in the hospital.

Question 27A. To what extent are VA social workers now used to coordinate VA health care and other benefits with available community services so that aging veterans do not stay longer than is necessary in VA facilities?

Answer 27A. As members of the health care team, social workers are responsible for identifying the "at-risk" elderly, providing consultation to other health care professionals concerning the impact of social factors on health care outcomes; and developing a social treatment plan that provides the critical link between the VA and the community service network in support of health care objectives. Social workers thus facilitate the movement of the patient through the VA health care system to an appropriate level of care in the community that not only meets medical care objectives but also supports his right and his need to direct his own affairs to the maximum extent possible. Social workers facilitate the development of needed community services through participation in community health and welfare councils; liaison with the Administration on Aging in all VAMC's and specialized demonstration programs (e.g., National Long Term Care Channeling Demonstration Program).

A significant proportion of social work time and resources are assigned to VA community programs which includes the provision of follow-up services to veterans in community nursing homes, residential care homes, Hospital Based Home Care Programs, and veterans residing in their own homes. Through the provision of linking, referral and follow-up services to the frail elderly, social workers insure that continuity of care is maintained for this vulnerable population.

Question 27B. Do you consider this to be a "case management" approach?

Answer 27B. Yes - The case management function encompasses concepts, knowledge, and skills that have been the foundation of social work practice in the VA for over 50 years. All social workers are, in fact, case managers. Their professional training, experience, and value system uniquely qualifies them for their role as consumer advocates who are able to match and facilitate linkage between patient needs and appropriate VA and community resources.

Question 27C. Is this approach effective?

Answer 27C. Yes - Although the case management model has been most extensively developed to meet the long term care needs of psychiatric patients, it has been increasingly effective in meetng the needs of GM&S patients who require noninstitutional supportive care in the community. The Residential Care Program was developed by social workers over 30 years ago as an alternative to institutional care for psychiatric patients. The General Accounting Office in a 1978 survey of the program recommended that this cost-effective modality be expanded to all VAMC's. The development of the Visual Impairment Services Team case management model was pioneered by social workers concerned about the lack of a coordinated service delivery system for blinded veterans. This model has been validated with the establishment of additional VIST coordinator positions within Social Work Service at designated VAMC's. Plans are in progress to extend the case management approach to all Spinal Cord Injury patients who receive their health care in VAMC's without an SCI unit.

Each of these VAMCs has been requested to designate a social worker to coordinate services for this population.

Question 27D. To what extent could it be applied to a comprehensive geriatric care program?

Answer 27D. We believe that a case management approach would be effective in providing health care services to the geriatric population. Social workers are an important part of any health care delivery team. They routinely provide information and referral services for the elderly and work with AoA, HHS demonstration projects and volunteers to develop a full range of community support services. Volunteers who are oriented and supervised by social workers can also function as extensions of VA staff in providing services to older veterans in their own homes or other community settings.

VACO Social Work Service is sponsoring a national workshop on "Community Options for the Aging Veteran" which will be held in Washington, D. C., in September 1982. One social worker from each medical district will be provided with specific training to function as a key resource person in linking the older veteran to VA and community support services. They will be prepared to provide consultation to medical center management and medical district staff in developing, integrating, and coordinating needed services to frail, elderly veterans and their families.

Question 28. **Are community based health care and social support programs for the elderly available throughout the Nation? Do these programs vary in quality and quantity?**

Answer 28. Yes there are community based health care and social support programs for the elderly in many communities in the country. Multipurpose senior centers began as a place where the well elderly could engage in a variety of activities. The range of programs and activities is very extensive, including a broad array of social/recreational activities, health servicing, information and referral, trips, educational classes, current events, nutrition classes, counseling and a hot noon meal. Some senior centers also have an adult day health care component. During the past three years the frail, impaired elderly have been included in programs at many centers. There are currently over 8,000 multipurpose senior centers. They are located in rural, urban, large, small and medium sized communities.

There are also many adult day health care programs in this country. These programs are specifically for the frail, "at risk," older person who needs nursing care, therapy, and other medical care services on a regular basis. These programs provide care for a more disabled population than do senior centers. In addition to the medical health services there are also many of the social/recreational and other activities provided by senior centers. Transportation services are usually also provided, especially for those using wheelchairs, walkers, etc. Staffing includes nursing personnel and therapists in addition to social workers and recreation staff.

There is considerable variation in the size, number and distribution of both types of programs. The National Institute of Senior Centers has established program standards. The National Institute on Adult Day Care is in the process of developing standards of care.

Personal care services refer to assistance in the activities of daily living which may be a covered service under a State plan for Title 19 of the Social Security Act. Only 15 states allow personal care as a reimbursable item. Title XX of the Social Security Act and Title III of the Older Americans Act of 1965 also cover personal care services although only a small portion of the funds are used for health related services.

Homemaker and chore services include laundry, shopping, house cleaning and yard work and is intended to sustain the elderly in their own homes. Title III of the Older Americans Act authorizes grants to States which may include homemaker services. States may also use Title XX grants for this purpose.

Home delivered and congregate meal programs provide meals to the elderly who cannot prepare their own meals. Funding for the home delivered meals, popularly called "meals-on-wheels," is from grants under Title III of the Older Americans Act on Title XX of the Social Security Act. Funding for congregate meals is under Title III and the meals are served in churches, senior centers, etc. In both programs recipients contribute the cost of the meal if they are able.

Medicare funds home health care which is oriented towards short term, acute care. This benefit is limited to those who are homebound, need skilled nursing care and one other approved service. Medicaid also funds home health services but the State has considerable discretion in the services provided. Home health services, consequently, vary from State to State.

The availability of personal care services, home and congregate meal programs, and home health care varies greatly, both among and within States. The statutory authority for Title 18 and Title 19 of the Social Security Act is biased toward institutional care and therefore limits access to home and community services.

Question 29. The VA Hospital Based Home Care (HBHC) program has not been expanded since 1974. GAO reported in 1981 that a large number of patients could be treated through the program, and that 48 Medical Centers had submitted proposals to develop services. Why has the VA not supported expansion of the HBHC program in those locations?

Answer 29. The VA's request for appropriations for FY 1983 was formulated under budget constraints so that plans for funding the program will be at the current level. Hospital Based Home Care has not been expanded during the past five years because of budget constraints and other priorities. DM&S will explore ways to expand this program throughout the system during the next couple of years.

Question 30. How effective has the HBHC program been at the 30 facilities where it is operational? What are the problems that have arisen with this program?

Answer 30. DM&S believes that the program has been effective in maintaining patients in the community who otherwise would be in an institution. Letters have been received from patients and their families expressing satisfaction with the health services provided by HBHC. The program has experienced considerable success in caring for patients with a malignant neoplasm.

Improvement in the program can be achieved by increasing the emphasis upon assisting patients who so desire to die at home. HBHC team training is being provided to increase skills and to emphasize this aspect of terminal care.

The Assistant Administrator for Program Planning and Evaluation is finalizing a report of a study of the HBHC program which will address the effectiveness and any deficiences in the program.

Question 31. Does the VA have any plans to expand the Independent Living Program to meet the needs of the aging veteran? If so, what would be the agency's needs in terms of staffing and other resources? Compare this type of extension to the program changes needed to accommodate blinded veterans, which the VA has announced will be undertaken.

Answer 31. The VA has 4 programs which provide Independent Living Services.

DVB

Public Law 96-466, "Veterans Rehabilitation and Education Amendments of 1980" expanded the mission of Chapter 31 to provide for all services and assistance necessary to enable veterans with service-connected disabilities to achieve maximum independence in daily living and, to the maximum extent feasible, become employable and to obtain and maintain suitable employment." There are three situations when independent living services may be provided under Chapter 31.

1. Vocational Rehabilitation Program - Service-connected veterans determined to meet basic eligibility requirements for Chapter 31 and determined to be vocationally feasible may be provided a wide range of independent living assistance when determined necessary for the veteran to train for or obtain employment. These services are provided in the same manner as any other Chapter 31 service and for the same duration.

With the exception of counseling and psychometric testing, most services are obtained through contracts with direct service providers or through DM&S facilities.

2. Extended Evaluation - Service-connected veterans determined to meet basic eligibilty requirements for Chapter 31 but for whom it cannot be determined whether they would be employable after receipt of services, may be placed in a period of extended

evaluation. During this period, generally not to exceed 12 months, all services necessary to answer the question of whether a veteran is vocationally feasible (i.e., capable of employment after services) may be provided. These services include all independent living services necessary to make a determination of vocational feasibility. If after a period of extended evaluation, the veterans potential for employment is still in question, the veteran will be determined to be feasible. This is because the law is very specific in that all questions of vocational feasibility will be resolved in favor of the veteran with a positive decision. Because of this, the predominate proportion of veterans referred for Chapter 31 services will be receiving independent living services within the context of a vocational rehabilitation program not than the Independent Living pilot program.

3. Independent Living Pilot Program - Service-connected veterans determined to meet basic eligibility requirements for Chapter 31 and determined to be vocationally infeasible may be provided independent living services when necessary to increase the veteran's ability to function independently or with a reduced reliance on others in the community. Any eligible service-connected veteran, including veterans on inpatient or outpatient DM&S roles or in nursing homes or domicilliaries, may be recommended for this pilot program even though they are not able to pursue a vocational rehabilitation training program. These services will be provided as in the manner described under "Vocational Rehabilitation Program."

Imperative to all programs is the integration and coordination between services, departments and agencies for identification, referrals and provision of Independent Living services.

DM&S

1. In the Department of Medicine and Surgery the rationale for funding an Independent Living Program focused on disabled veterans who are confined to institutional settings and who do not have the best environment to learn how to become as self-sufficient as possible. The sheltered nature of institutional environments prevents them from achieving their full potential. In addition, institutional environments generally contain a limited amount of resources which can be used by veterans to increase their level of self-sufficiency. As a consequence, many veterans are confined to hospitals for longer periods of time than necessary. Although it is unrealistic to expect all disabled veterans to achieve total self-sufficiency, efforts made to increase the degree of independence should not only enhance the quality of veterans' lives but also reduce the overall health care costs of the disabled population through less reliance upon outside assistance.

2. In FY '80 the following six Independent Living pilot centers (one per medical region) were funded:

VAMC Northport, NY
VAMC Richmond, VA
VAMC Little Rock, AR
VAMC Topeka, KS
VAMC Milwaukee, WI
VAMC Los Angeles (Wadsworth), CA

Each center was authorized four FTEE to develop and implement programs in a cooperative effort with DVB and the community. The objective of Independent Living Services was to provide the range and combination of services which would enable disabled veterans to live and function at their maximum level of independence within the community. Therefore, each center was responsible for the establishment of a program to meet the needs of their veteran population in conjunction with available community resources. These programs provide direct services, resources, and referral to appropriate agencies for necessary assistance. Their patients include service-connected and nonservice-connected, inpatient and outpatient, SCI, the aging, neurologically and psychiatric impaired or any other severely disabling disease entity or handicap. Services include transitional living, housing, peer couseling, attendant training, driver training, activities of daily living, communication skills, vocational training and placement, community education and referral financial assistance, family counseling, adaptive equipment or home modification, health service maintenance, independent living skills, recreation, etc. While veterans also receive many of these services at other VA Medical Centers, the pilot programs focus on a coordinated approach both in the VA and for follow-up in the community. Veterans who need Independent Living services from one of the centers may be considered for transfer from another VA Medical Center within the medical region. Also, a service-connected veteran identified as meeting eligibility requirements under Public Law 96-466 can be referred to one of the centers for a program of Independent Living but specific services may be contracted or purchased within the community.

Blind Rehabilitation Centers

The VA's Blind Rehabilitation Service has undertaken 4 major steps to meet the needs of blinded or low vision veterans.

1. Expanded the Visual Impairment Services Teams to 24 FTEE Coordinators.
2. Opening of the Blind Rehabilitation Centers in Birmingham, Alabama, September 17, 1982.
3. Expanded the number of beds in 2 of the 3 Blind Rehabilitation Clinics.
4. Assessed the current Blind Rehabilitation Programs to meet the needs of the increasing blinded geriatric population.

Question 32. Would the VA support modification of this program to allow the development of a model Independent Living Center Program for aging veterans? Do you believe that legislation would be needed to accomplish this goal?

Answer 32. The VA already supports 6 model Independent Living Centers which include services for aging veterans. There is no reason for the development of separate programs specifically for aging veterans. While the focus of independent living is on severely disabled veterans, a large percentage of these veterans are in the aging category and are provided services.

Question 33. Where would you suggest locating such an effort, in the sunbelt, on the site of a GRECC or where?

Answer 33. The location of such a program should be determined through competition based on criteria to assure the most effective evaluation of this approach to care for the aging veteran.

Question 34. Would this be a logical model to use for trying out a program which would allow the VA to administer programs and provide training within local communities for certain elderly veteran patients?

Answer 34. Not necessarily, however, a focus in Independent Living for the aging veteran should be the central theme for joint VA—community participation providing services and community resources to the aging veteran. This particular program as established by P.L. 96-466 has not been evaluated as a mechanism for accomplishing this purpose.

Question 35. Explain specifically the proposed Independent Living Program modifications which will be undertaken to meet the needs of blinded veterans.

Answer 35. Currently, other then the VA Blind Centers there are no proposed Independent Living programs specifically for blinded veterans. However, both under PL 96-466 and DM&S Independent Living programs, any service necessary to assist a veteran to become more independent in daily living may be obtained provided he/she is eligible under Chapter 31. However, the DM&S model Independent Living programs provided an expansion of services to both service-connected and nonservice-connected blinded veterans beyond what is offered at the Blind Centers. This includes vocational rehabilitation or any other services which assist in their independence.

Question 36A. How would this program compare to the existing Blind Rehabilitation Centers?

Answer 36A. Blind Centers provide an adjustment to blindness training. DM&S model programs have the capabilities of providing any service available within the VA Medical Center or the community and focuses on services not provided by the Blind Center such as vocational rehabilitation and community adjustment.

Question 36B. Would specialists in blind rehabilitation be used?

Answer 36B. Blind rehabilitation specialists would not be necessary for training in Independent Living programs but could be utilized as consultants when available or needed.

Question 36C. Would the Director of the VA's Blind Rehabilitation program coordinate his skills with the Director of Vocational Rehabilitation who is charged with responsibility for the Independent Living Program?

Answer 36C. PL 96-466 currently makes no provision specifically for blinded veterans. However, if emphasis was placed in this disability group, coordination between the two services would occur. The limitation in this situation however, would focus on only service-connected veterans who do not have employment potential.

Question 36D. Would this program be used for blinded veterans of all ages, those with multiple disabilities, or those with no feasibility of pursuing a vocational goal?

Answer 36D. If such a program were developed all veterans should be eligible regardless of disability and age and vocational rehabilitation should not be a factor for eligibility.

Question 36E. Would these veterans have to be service-connected in order to participate?

Answer 36E. In the DM&S Independent Living program all veterans should be considered with priority to service-connected. This is currently the way in which DM&S model programs select patients for their Independent Living.

Question 37. Does the VA have any plans to coordinate with community based organizations in order to provide specific readjustment and independent living services for aging, multiply disabled blinded veterans, who would not be interested in a vocational goal and who may be incapable or fearful of traveling to a Blind Rehabilitation Center?

Answer 37. The entire focus on DM&S Independent Living programs is to coordinate with community resources in order to assist veterans in living independently in the community. However, if services are not available within the community VA resources are utilized.

Question 38. Could the traveling clinic in Cheyenne be expanded to serve the homebound elderly patient?

Answer 38. For a home health care program to be cost effective, the amount of care provider time spent in travel to and from the patient's home must be minimized. There are indications that the HBHC Program would be more cost effective than a traveling clinic for the homebound elderly patient. The traveling clinic involves several health professionals providing care in one group visit. Data from a recent survey indicate that the amount of time HBHC providers spend with patients in direct care in the home, forty-one minutes, is nearly twice the amount of time spent in travel, twenty-three minutes. Generally, home visits are made by a single provider so that the number of days between visits is lessened and the number of patients contacted is increased. For the past three years the Little Rock, Arkansas, HBHC Program has been providing Rural HBHC services from a satellite office in Hot Springs as a demonstration project. The four providers who generally make home visits singly are located in Hot Springs and are assisted by the HBHC staff in Little Rock where the program administration and coordination is accomplished. Through this satellite program, a rural, medically underserved population is reached at minimal cost and the primary service area of Little Rock vastly expanded. Provider time spent in travel from Hot Springs represents only 5% of the total operating costs. This project has proven its success and demonstrates the possibility of rural/urban cooperation in the delivery of health services.

Question 39A. Does the VA plan to implement the Preventive Health Care Program, authorized in Public Law 96-22?

Answer 39A. The VA has implemented a pilot program to deliver preventive health care services to certain veterans with service-connected disabilities, emphasizing investigation of the cost-effectiveness of such services. Six projects (all initiated in FY 81) are being supported at a level requiring $500,000 and 18 FTEE per year through FY 1984. Constrained resources preclude funding additional activities from the Health Services Research and Development (824) appropriation.

Question 39B. Could this program be modified to meet the needs of elderly veterans?

Answer 39B. Problems of the elderly can be addressed under the current legislation, although the limitation of the program to service-connected veterans might be a constraining factor in some studies. Some of the currently funded studies focus on chronic conditions prevalent among the aging veteran population such as hypertension and cardiovascular disease.

Question 39C. If so, does the agency have plans to do so?

Answer 39C. The agency has no plans to request modification of the existing legislation pertaining to the pilot program in preventive health care.

Question 40A. Is VA Domiciliary treatment, such as psychological or psychiatric treatment and active medical and physical therapy, currently provided within the domiciliary, or at other locations at each station?

Answer 40A. Fourteen of the 16 domiciliaries have a domiciliary medical clinic in which "sick call" and other minior medical care is provided. A patient needing to be referred to a specialty clinic is referred to clinics in the ambulatory care area of the medical center. At two medical centers with domiciliaries, the domiciliary medical clinic has been eliminated and physicians in the ambulatory care area serve as primary physicians to domiciliary patients. Clinical staff from Psychology, Social Work, Dietetics, Rehabilitation Medicine, Nursing, and Recreation Services are assigned to the domiciliary and provide programs specifically geared to the needs of domiciliary patients. At all sites domiciliary patients are incorporated into medical center programs where this seems the best approach.

Question 40B. Will this change as a result of the VA's reassessment of the domiciliary program?

Answer 40B. There will be an effort to eliminate the domiciliary medical clinic and have patients obtain necessary medical care in the outpatient area. Where feasible, domiciliary patients will be incorporated in hospital clinics and programs; however, specialized programs will continue to be provided in the domiciliary by clinical staff from various professional services. A major change of the reassessment will be the focus on helping domiciliary patients return to a community level of adjustment. Some of the discharge preparation can best be done in the domiciliary setting while some will take place out in the community.

Question 41. Could domiciliary patients be provided room and board in the domiciliary, and go to the outpatient clinics of the hospital for care and therapy?

Answer 41. This has been partially answered in the preceding question. Much more than room and board is and should be provided in the domiciliary. It is a therapeutic milieu which encourages development of independence on the part of patients, involvement in the planning and decision making regarding their future, and participation in a therapeutic community. Whenever possible, the plan is to organize the medical care for domiciliary patients so that it will be delivered in the outpatient area. This will provide a similar model of care delivery to that which they will use when living in the community. At present, domiciliary patients requiring specific rehabiliation therapies for disabilities receive it in the main rehabilitation clinics in the hospital. Treatment programs and activities will continue to be provided in the domiciliary by staff with special ability to treat these chronic patients.

Question 42. What percentage of domiciliary residents return to the community to live?

Answer 42. The data are not available to provide an exact answer to this question. A data collection system will soon be in effect that will provide that information on a monthly basis. However, there has been an increasing number of domiciliary patients returning to community living in the past several years. There has been a good success rate, too, in these patients not being readmitted to the domiciliary.

Question 43. What is the average length of stay in a domiciliary?

Answer 43. In September, 1980 the average attained length of stay was four years, one month. However, 28% of domiciliary patients had been in the domiciliary for from five to over fifteen years since their current admission.

Question 44. Has the VA considered methods (in addition to percent reduction of nonservice-connected pension) to reduce the existing financial incentives which encourage domiciliary residents to remain dependent upon VA domiciliary care?

Answer 44. Yes. We do not believe that it is financial incentives alone that have made these veterans dependent on domiciliary care. Although the majority of domiciliary patients have a very limited income, the dependency comes from other factors. This is a medically and psychologically disabled population. Unfortunately until the late 1970's (1978) comparatively little had been done to encourage domiciliary patients to return to live in the community. It was assumed that once a patient was eligible for domiciliary care, he/she could remain there indefinitely. Therefore, many domiciliary patients were made institutionally dependent. A number of programs have been developed in domiciliaries to reverse this trend and more needs to be done. Programs such as discharge preparation, life skills/socialization skills training, coping skills, leisure education, patient-health education programs, vocational rehabilitation through live in/work out approaches, etc. are helping domiciliary patients accept and participate in discharge planning. Most domiciliary patients have long histories of institutional care. At the time they were discharged from VA hospitals, domiciliary care was seen as the best alternative for them. Another approach that is proving useful in returning patients to the community is the approach in most domiciliaries whereby the discharge plan is started at admission. Thus, the veteran knows right from the beginning that domiciliary care is time limited. VA is considering the implications of suggestions that creating eligibility for outpatient care on a "post domiciliary care" basis might facilitate discharging such patients.

Question 45. Has the VA explored the possibility of offsetting or reducing Social Security benefits for residents?

Answer 45. No. During a recent inquiry it was determined that of 7,247 patients receiving domiciliary care, 2,215 were receiving Social Security retirement benefits, and 1,397 Social Security disability benefits. When receiving any type of Social Security benefits and a VA nonservice-connected pension, the total amount received by a single veteran with no dependents does not exceed the full amount of the pension. If a veteran is receiving Social Security retirement benefits, these are monies due him/her because of contributions to the plan while gainfully employed. Similarly, patients receiving Social Security disability benefits are eligible because of the degree of disability. For veterans returning to the community the fact that they are receiving such monies enable them to develop a "nest egg" to pay for housing, food and care. With the current cost of living, the $60 per month retained by patients is not sufficient to pay for clothing, toiletries, incidentals, outings, etc., as well as save toward community living expenses.

Question 46. Has the VA considered charging residents for room and board on a sliding scale based on income?

Answer 46. No. As a level of medical care it would be inappropriate to charge patients for room or board. Domiciliary care is not room and board. If the domiciliary patients were to be charged for their care, then patients occupying nursing home or hospital beds should similarly be charged. Patients in domiciliaries need ambulatory medical care in an institutional setting. In addition to medical care, a range of community support services are provided. These focus on preparing patients to return to a community level of adjustment at the earliest possible time. A number of years ago, in the early to mid-seventies, when the domiciliary was widely considered a residential setting, some consideration was given to assessing a charge for care. However, that approach was not deemed workable.

Question 47. I understood that there is now an income limitation of $415 per month for nonservice-connected veterans who are admitted to domiciliaries, and that applicants with higher income are presumed to be able to live elsewhere. This implies that economic circumstances are a very important factor in determining whether a patient is receiving care in a VA domiciliary. Is that correct?

Answer 47. The amount of income received by an applicant for domiciliary care is important based on the statutory provisions that the veteran "has no adequate means of support" (38 U.S.C. § 610(b)(1)) or "is unable to defray the expenses of necessary domiciliary care" (38 U.S.C. § 610(b)(2)).

Question 48. Where do applicants with slightly higher incomes go? Are they placed in residential care homes? If so, what else differentiates residential care patients from domiciliary patients?

Answer 48. Applicants with slightly higher incomes are counseled as to possible alternatives. Placement in the Residential Care Home Program under VA supervision would be possible if the veteran is a patient in a VA hospital or has outpatient status. Patients in domiciliaries are considered to need an institutional level of care, including medical care on a regular basis, the support services provided, the structure of an institutional setting, and minimal supervision provided.

Question 49A. If the VA had the authority to supplement the income of domiciliary patients so that they could qualify for residential care, what portion of current domiciliary residents would be appropriate for residential care?

Answer 49A. In a survey of the domiciliary population in September, 1980, data indicated that if sufficient resources, including income, staff to effect placement, and homes were available, 24% of domiciliary patients would be appropriate candidates. Data from the same survey indicated that 83% of domiciliary patients, if discharged and, with full pension restored, would have had a monthly income under $400 per month.

Question 49B. How long would it take to place them?

Answer 49B. The survey indicated that if all resources were available the placement time would typically range from one month to one year. The factors involved in preparation for placement include the availability of residential care homes; the appropriateness of the residential care home for the individual patient; the establishment of a fiduciary when the patient is rated incompetent to handle VA funds (17% of all domiciliary patients), and the preparation of the patient to resume community living, especially if the veteran has been institutionalized for many years.

Question 49C. Has the VA studied the cost-effectiveness of such a proposal?

Answer 49C. While the VA has never undertaken a formal cost-effectiveness study of this proposal, a current review indicates a potential yearly savings of $2.1 million. This potential savings is the difference between the reduction in direct patient cost in the domiciliaries and the additional administrative cost for the Residential Care Home Program. This savings could be realized if three assumptions hold true. First, all domiciliary patients who were identified as having the potential for outplacement if necessary resources were available, are, in fact, placed in residential care. Second, the rate of increase in administrative cost to the VA for the Residential Care Home program remains constant. Third, and most importantly, no domiciliary patients would replace those patients who are placed in residential care. This assumption is most unlikely as the VA provides domiciliary care to only 6 percent of the veteran population in need of such care. No savings are likely to accrue to the VA unless these assumptions are met.

Question 49D. Does the VA have any other plans to expand the present scope of the residential care program, so that more elderly patients who would also benefit from such care would be able to participate?

Answer 49D. Currently, there are approximately 12,700 veterans in the Residential Care Home Program. In Fiscal Year 1981, fifty-eight percent of veterans were over 55 years of age at the time of placement, and 28% were over the age of 65. The average is expected to increase as the average age of the total veteran population increases.

The Residential Care Home Program was originally designed to serve a psychiatrically disabled population who no longer needed hospitalization, but were unable to function in the community without the care and supervision provided by residential care. For several years, the Department of Medicine and Surgery has made an effort to expand this program to serve general medical and surgical patients. (Three regional conferences have been convened to train VA staff in the benefits of residential care for such patients). While the population of the RCH program still largely consists of a psychiatric population (80%), the general medical and surgical population is growing (14% of patients placed in FY 1982 were GM&S patients) and it is from this population that we expect to serve a largely frail elderly group of patients with multiple chronic medical disabilities.

In expanding this program to serve the needs of a veteran population which is vulnerable by reason of its physical or mental disabilities, the VA needs to insure that homes providing care to beneficiaries meet reasonable standards for health and safety. In order to fulfill this obligation to disabled veterans, the VA has proposed legislation which, if enacted, would provide the agency with clear and specific authority to operate and set standards for this cost effective program which is currently operated only under the general authority of the Administrator.

Question 50A. I understand that the VA Inspector General recently recommended renovation of existing domiciliary facilities instead of new construction of such facilities. In light of the I.G.'s recommendations, what are the VA's plans for future construction or renovation of the domiciliary program?

Answer 50A. The VA is in the process of evaluating the condition of present domiciliary facilities to determine if renovation would be cost effective in remedying life/safety, seismic, and privacy deficiencies in order to provide a facility in which a minimum level of medical care is given. Renovation will be the course followed whenever possible. Such renovation would include capability to provide domiciliary care for women veterans and for those veterans requiring handicapped accessibility. If renovation is not cost effective and does not meet programmatic requirements, new construction will be considered.

Question 50B. What justification was used to support the recent plan to build one new domiciliary in each Medical District?

Answer 50B. The former plan to provide a minimum of 200 domiciliary beds in each medical district is no longer in effect. That plan did not envision a new facility in each medical district. It provided for renovation of existing beds wherever feasible. The plan was developed to provide improved geographic dispersion of domiciliary beds so that veterans could obtain domiciliary care closer to their homes.

Question 51. I understand that previous plans would have resulted in a decreased number of domiciliary beds from about 8,000 beds to about 5,600 beds. How does such a decrease relate to the demographic trends among older veterans, and your current estimate of need for domiciliary care?

Answer 51. Reduction in the domiciliary program, which is now considered the lowest level of medical care, is in line with the balance which the VA is attempting to reach in its allocation of health care resources to meet the needs of the aging veteran population. There appears to be substantial need for such a program. Similarly, there exists a substantial need for nursing home care as well as other programs the department offers. The reduction of the Domiciliary program will permit the department to reach a more balanced delivery of health care consistant with the needs of the veteran population.

Question 52. **Have you considered any new alternative uses of the domiciliary level of care to better meet the needs of the changing veteran population?**

Answer 52. Yes, and several are already in process. Whereas the typical domiciliary patient is a World War II veteran, there is an increasing number of veterans in the younger and older age brackets applying for domiciliary care. One approach is to develop and provide programs to meet the unique needs of specific populations. Another is to provide programs for specific diagnostic categories. For example, several domiciliaries have developed stroke rehabilitation programs for patients who are medically stable and no longer in need of acute rehabilitation services, but who require continued maintenance rehabilitation in order to function more independently. Another is to enable patients requiring dialysis to give themselves home dialysis in the domiciliary thus releasing a hospital bed for another patient. Also, cancer patients on chemothreapy can be in the domiciliary in between courses of therapy. The use of domiciliary care for patients in the first stage of Alzheimer's disease is being explored. Some domiciliaries already have a limited number of such patients. A close association with community vocational rehabilitation programs would enable some nonservice-connected veterans to obtain such training while undergoing needed medical care in the domiciliary. For aging veterans requiring continuing domiciliary care, programs to enable them to be integrated into community groups will do much to increase their self-esteem, expand their social contacts with peers and make them feel like contributing members of the community. With the domiciliary considered as an active rehabilitative focused program, additional alternative uses of domiciliary care will continue to be developed.

Question 53. What is your current thinking about the appropriate role for extended hospital care over the next twenty years?

Answer 53. With the growing numbers of aged veterans and the increased incidence of chronic disease in this population, extended hospital care (called Intermediate Care in the VA) should play a larger role in the continuum of care available over the next twenty years. Extended hospital care is appropriate for patients needing a level of care between acute hospital and long term or extended care (such as that provided by a nursing home.) The patients are not acutely ill, are medically stable and have few diagnostic problems. However, they do need substantial nursing and/or rehabilitative therapy as well as regular evaluation by physicians to achieve maximum hospital benefit. Ideally the patient should progress to either a noninstitutional setting or an extended care facility.

Question 54. What types of patients should be cared for in an extended hospital setting?

Answer 54. Patients should be cared for who are chronically ill and require a more or less daily intervention by physicians appropriately supported by laboratory and X-ray capability. Some examples are patients with difficult heart failure management problems, long term malignancies, complicated pulmonary disease, and those with unstable diabetes.

Question 55A. What differentiates highly impaired extended hospital care patients from similiarly impaired skilled nursing facility patients?

Answer 55A. The distinction between extended hospital care patients and nursing home care patients rests solely on the need for direct medical intervention by a physician. Extended hospital care patients are not medically stabilized and require frequent intervention by physicians to monitor and correct frequent changes in the patients' status. Nursing home patients, on the other hand, although they may require intensive nursing care, require only intermittent (e.g., once a week) medical intervention.

Question 55B. If extended hospital care did not exist, where would these patients be cared for?

Answer 55B. These patients would probably be cared for in acute hospitals or nursing home beds. In both instances, the solution would not be as cost effective as extended hospital care.

Question 56. **What differences in staffing patterns, equipment, and facilities exist between extended hospital care and VA nursing home care?**

Answer 56. The staffing ratio of physician to patients is approximately 2.5 times greater for extended hospital care than for nursing home care. Similarly, the ratio for nursing (RNs and NAs) is approximately 2.4 times greater. The ratios are also greater for other health care professionals for extended hospital care.

The differences in equipment relate directly to the level of care provided. Equipment in extended hospital care is primarily for medical treatment, while that in the nursing home is for rehabilitation and nursing care.

The difference in facilities between the two programs is in certain space requirements. Nursing homes have adjacent facilities specifically designed for large group dining, recreational activities and rehabilitation therapies. Extended hospital patients have access to the above functions but the space is situated in other areas of the hospital.

Question 57. What case management systems are in place or projected that will reduce system fragmentation and assure cost-effective use of extended care services? How are the various types of long term care now coordinated?

Answer 57. The availability of VA extended care services varies. Not all medical centers have domiciliaries, nursing homes, access to State veterans homes, hospital based home care, etc. Moreover, case management systems vary according to the needs and preferences of specific VAMCs. Local advisory committees and outside peer reviews of extended care assure good program utilization and teams monitoring the quality of patient care in contract nursing homes or residential care homes assure good care of veterans in non-VA facilities. Generally speaking, multidisciplinary teams for planning and executing care plans for individual patients are used more than case management because the pattern of specific needs of extended care patients are relatively diverse. What is needed is better overall coordination of hospital, extended care, and outpatient services. The VA has recently issued a circular recommending the VAMCs establish committees to study ways of improving coordination of services within a medical center. The MEDIPP process is expected to focus on ways to better distribute and use extended care services throughout each medical district. Several VAMCs which have a variety of extended care programs have established positions for an Associate Chief of Staff for Extended Care which provides a basis for coordinating extended care programs. The success of this approach is being monitored carefully.

Question 58. Has the VA determined the present size of the long-term care psychiatric patient population within the VA system?

Answer 58. On the last census day, June 24, 1981, the Office of Reports and Statistics reported there were 10,470 patients with psychosis who had been in the hospitals more than 90 days, and 2,995 patients with other psychiatric disorders within the hospitals in excess of 90 days or a total of 13,465 patients in long-term psychiatric care.

An estimated total of 28,672 long-term psychiatric patients were treated in VA medical centers during Fiscal Year 1981. This figure is determined by adding the 13,465 patients in the hospitals on census day and the 15,707 patients with a psychiatric diagnosis who were discharged during Fiscal Year 1981 who had more than a 90 day length of stay.

Question 59. What projections have been made about future demands for VA long-term psychiatric beds?

Answer 59. More definitive projections of demands for VA long-term psychiatric beds will be furnished through the MEDIPP process, however preliminary projections provided by the Office of Program Analysis and Development indicate a need for approximately 10,000 VA extended psychiatric care beds for 1990 based on the VA/GAO bed sizing model. It is assumed that many long-term psychiatric patients will be treated in intermediate medicine beds, nursing home care beds, domiciliary beds and personal care home programs and hospital based home care programs. It is also assumed these alternate health care facilities will be available.

Question 60. What type of facilities presently exist to deal with older chronic psychiatric patients?

Answer 60. The hospitals with larger psychiatric populations all have facilities to deal with older chronic psychiatric patients. Approximately 62 percent of the VA hospitals have special psychogeriatric programs. As patients age some develop other types of diseases such as diabetes, arthritis, hypertension, etc., and they are transferred to intermediate medical wards or to nursing home care. Patients who require a minimal level of medical care and minimal personal supervision may be transferred to domiciliaries. A number of long-term elderly patients with chronic psychiatric disorders are able to be cared for in the community by their families. These patients report back to the Day Treatment Centers, or if a facility lacks a Day Treatment Center, to the Mental Hygiene Clinic for supervision.

Question 61. What mechanisms exist to ensure that VA hospitals without an appropriate level of care can transfer these patients to facilities which can treat them?

Answer 61. Each medical district, with a few exceptions, has a hospital with a large psychiatric patient population to which hospitals within the district may transfer patients on arrangements between the two hospitals. The same system applies for transferring patients from the psychiatric ward to intermediate medicine, nursing homes, or domiciliary, depending on the needs of the individual patients.

Some medical districts lack long-term psychiatric care. The projected plans for construction will eliminate this deficiency. In the interim, patients are transferred to adjacent medical districts. For example, patients within Florida are transferred to Augusta, Georgia, or Tuscaloosa, Alabama, although the facilities there are becoming overburdened and there are plans to build long-term beds at Gainesville.

Question 62A. What specific plans has the VA developed to manage and treat patients suffering from early stages of senile dementia?

Answer 62A. We are developing psychogeriatric units within the psychiatric services of our hospitals with large mental patient populations. There are post-graduate seminars for our staff in detection and management of the earlier stages of Alzheimer's type of senile dementia. We are cooperating with the Office of the ACMD for Extended Care and Geriatrics in planning for the care of psychiatric patients within their services.

Question 62B. Can the VA effectively treat these patients and assist their family caregivers to enable the patients to remain in their own homes?

Answer 62B. We do effectively treat a number of patients and we do assist their family caregivers to enable the patients to remain in their own homes. Psychiatric input is to carry on educational programs with patients and families prior to discharge. The Office of the ACMD for Extended Care and Geriatrics also have personal care homes and hospital based home care programs to assist in maintaining patients in their own home.

Question 63. Is there a role that domiciliary care, with modified staffing patterns, could play in managing senile dementia patients?

Answer 63. Many older patients are now sent to a domiciliary. If the Alzheimers type of senile dementia progresses beyond a point where they can no longer care for themselves, domiciliary care is not appropriate and they are transferred to a nursing home. Currently, a large number of patients with long-term schizophrenia, or organic brain disease including Alzheimers senile dementia are cared for in domiciliaries.

Question 64. I understand the VA estimates that about 50,000 veterans will suffer from senile dementia in 1990. It is also my understanding, however, that some experts calculate that at least 4% of the elderly suffer from some form of senility by the time they reach 65 years of age, which would equal approximately 280,000 veterans in 1990. Can you account for the difference in these two estimated figures?

Answer 64. The estimate of 50,000 veterans that this question mentions comes from Table E-7 on page 68 of Senate Print 12, "The Aging Veteran." The actual figure (48,512) represents the total estimated number of male veterans with senile dementia in 1990. This estimate is based upon the measure of cumulative morbidity risk for males derived by Larsson, Sjogren, and Jacobson in their 1963 study (footnoted on page 88).

Estimates of the relative number of persons with severe senile dementia range from 1.3 to 6.2 cases per hundred, but none of these are based on prospective studies. The Larsson, et al, work, upon which the VA figures were based, is good in that it comes from a 30 year study (1931-1960) in a stable setting, yet conservative because it relies exclusively on the recorded age-specific incidence of first admissions to psychiatric hospitals. This procedure probably underestimates the prevalence of the disease, because a number of studies, including that of Larsson, et al, found that the majority of cases identified were living at home at the time of the survey. Using the hospitalization rate to derive the cumulative morbidity risk of the disease is reasonable for the VA, since such diagnoses would be made only after admission to a VA hospital.

Over the years, the relative number of older people in the population has been increasing and the criteria for diagnosing senile dementia have been changing. Consequently, prevalence rates for the disease have been changing as well. Certainly some estimates of prevalence rates have been higher than those found in Larsson's study, but there appears to be no compelling reason for choosing a higher prevalence estimate unless further studies justify it.

Question 65. According to some estimates, one half of the nursing home admissions last year nationwide were people with Alzheimer's disease. Was that estimate also true for VA nursing home admissions?

Answer 65. Information obtained for the Fiscal Year 1981 annual census of VA nursing homes on the day the census was taken showed that of 8,306 patients, 18.1 percent of the patients (1,505) had a primary diagnosis described as dementia, with or without an implied or specific cause. Of the total with dementia as a primary diagnosis (1,505), there were 1,095, or 13.2 percent, coded as "non psychotic" who had mental defects severe enough to present many of the same problems and management needs as for those classified as "psychotic". The diagnoses are:

Code	Number of Patients	Percent
Senile and presenile organic psychotic conditions	111	1.3
Alcoholic psychoses	165	2.0
Other organic psychotic conditions (chronic)	134	1.6
Specific nonpsychotic mental disorsders due to organic brain damage	1,052	12.7
Other extrapyramidial disease and abnormal movement disorders	43	0.5
TOTAL	1,505	18.1

Question 66. To what extent is the VA planning to meet the needs of an increasing number of progressively deteriorating senile patients through the development of a home and community support system?

Answer 66. The VA will be exploring the extent of community support programs that can assist in maintaining such patients in their own homes for as long as possible. Some adult day health programs can assimilate a limited number of these patients in their programs thereby providing relief for families from 24-hour, seven day a week caretaker responsibility. It is essential to provide some respite for families to avoid "burn out." Occasionally, adult day care programs are found that specialize in the care of patients with Alzheimer's disease. Existing VA adult day health programs will be encouraged to accept Alzheimer's patients.

Question 67. To what extent is the VA developing the capacity for rapid differential diagnosis and treatment of senile and pseudo dementias within its acute care system?

Answer 67. The Mental Health and Behavioral Sciences Service and Neurology Service have been working with Extended Care in developing a set of policy guidelines for diagnosis and treatment of Alzheimer's disease and dementia in general. As there is no specific or effective treatment, management is a matter of differential diagnosis, treatment of any treatable complications (e. g., pneumonia), social support, and addressing quality of life issues. These factors will vary between patients and over time in the same patient. The guidelines offer a framework for making decisions and recommend the appropriate management efforts at various stages of the disease. Implementation will require concentrated educational efforts on changing attitudes about the hopelessness of Alzheimer's disease and the futility of treatment.

Question 68. What steps has the VA taken to facilitate the identification of such patients presently within extended care programs?

Answer 68. Our continuing education programs for staff have put a heavy emphasis on proper identification of such patients. Also, the VA is preparing a program guide on progressive dementia that should lead to better and more uniform diagnostic procedures.

Question 69 A.

I recognize that a great deal of research on Alzheimer's disease has been done at the eight VA Geriatric Research, Education and Clinical Centers (GRECCs). A. How has this research benefited actual treatment of Alzheimer's disease at VA hospitals?

Answer 69A.

The etiology of Alzheimer's disease remains elusive after considerable effort by numerous research investigators around the world. Without knowing exactly what causes Alzheimer's disease (or diseases), specific treatment(s) is, as well, unknown. Therefore, many VA research projects have focused on the differential diagnoses of Alzheimer's disease. The Seattle, Minneapolis, and Bedford GRECCs have specifically focused on this subject. Of all dementias seen in the aged, an estimated 25 percent are treatable. The remaining 75 percent are now categorized as irreversible dementias (Alzheimer's disease accounting for approximately 50 percent of these dementias). While Alzheimer patients are treated for signs and symptoms of the disease, VA family treatment programs have been initiated. Through counseling of spouses and children the VA seeks to inform the family of the expected progression of the disease. Through this direct intervention and working with national organizations (e.g., Alzheimer Disease and Related Disorders Association) a support network is established to help the patients and their families cope with their situation.

The VA also sponsors research with expected clinical application. For example, at the Seattle GRECC the sleep patterns of Alzheimer patients is being investigated. This research has shown that Alzheimer patients, even in the early stages of the disease, have a disturbed sleep pattern. These results have aided the diagnosis of Alzheimer's disease plus providing specific information that may be helpful in understanding the etiology of the disease.

Another research study with direct patient treatment benefits has been a study considering the use of antipsychotic drugs. This study was conducted at the Seattle GRECC and focused on the resulting behavioral responses when antipsychotic drugs or placebos were used. The results showed that only when the patient demonstrates uncooperativeness, agitation, hostility or excitement, of some twenty behavioral responses monitored, are the drugs better than the placebos. With these results, there has been an increased emphasis on reducing the drugs given to patients diagnosed with Alzheimer's disease.

A model clinical program has been started at the Seattle GRECC where diagnosed Alzheimer patients are first seen as outpatients, hospitalized on an acute basis as needed for up to a month, then for a limited number of patients, long term care at the American Lake VA Medical Center. This program not only provides specific care of patients but also encourages health care teams to collect specific medical data on the life course of Alzheimer's disease. These data could prove invaluable as the etiology is investigated in concurrent studies involving fluctuations in the body's chemistry.

At the Minneapolis GRECC, epidemiology studies are ongoing to determine the prevalence of Alzheimer's disease. It was previously thought that the disease was inevitable with aging if the person lived long enough. Preliminary results of this study are showing this may not be the case. Individuals who are 85 years old to 100 years old are being examined and an increase in the incidence of the disease has not been recorded. These results are important as we seek to understand more about prevalence of Alzheimer's disease.

Of equal importance, and emphasized in many research programs, is the education of health care providers. In the past, misconceptions, myths, and the availability of drugs have guided many treatment protocols for patients with dementia. Through this research, facts are replacing misconceptions. The expectation is that diagnoses and treatment in the future will be much more definitive and subsequently more effective than have been used in the past.

Question 69B. Should a more direct link to treatment be established?

Answer 69B. The present VA programs and policies continue to encourage the link between research and treatment. Quality patient care and protection must be carefully monitored as improvements in our understanding and treatment of diseases are sought. Through the GRECC program, as well as throughout the VA system, the care provider is often the research investigator. As effective treatments are tested and proven in a controlled population, then a larger system usage is encouraged.

Question 69C. Would a model "aging" pilot program on a GRECC site be a helpful way to link research with patient care?

Answer 69C. The VA concept of the GRECC program is that it is the link between innovative aging research and quality patient care. Presently, pilot programs are encouraged at all VA medical centers in the form of research protocols which are scientifically reviewed, then, if approved, conducted on carefully controlled and monitored populations. Results are reported to the scientific community through peer reviewed journals and national scientific meetings. These opportunities encourage new treatment concepts and relevant studies to be conducted.

Question 70. Does the VA routinely offer referral assistance for Alzheimer's patients who are turned away from treatment in VA health-care facilities?

Answer 70. Social Work Service interviews applicants who are determined to be ineligible for VA care but who are in need of health care and other community support services. Based on an assessment of the applicant's medical, psychological and social requirements, referrals are made to the most appropriate community, state, or federal resource.

Question 71. I am aware that there is one "official" hospice program, at the Los Angeles (Wadsworth) VAMC. Other VA hospitals have recognized a need for this type of program, and seem to be unofficially providing hospice-type care. What are the differences between the official hospice and these so called "defacto" hospices?

Answer 71. The Palliative Treatment Program at VAMC Wadsworth is a full service hospice consisting of a separate inpatient unit of eleven beds, a Hospital Based Home Care Unit, a Hospital Consultation Unit, and a Volunteer Unit. Twenty medical centers conduct hospice-like activities through a staff committee concerned with terminal care. Activities may include palliation and pain control, symptom control, counseling of the patient and family, and bereavement counseling for the family.

VAMC Hines also has a full service hospice but on a "scatter" model in which terminal patients are mixed with intermediate care patients on a ward. In this model there is no fixed number of hospice beds, so that when a patient is readmitted to the hospital he can be in the same ward. Staff try to limit the overall number of beds available for hospice care to fourteen.

Question 72. What types of patients can benefit from hospice care in the VA system?

Answer 72. It is our opinion that hospice care should be limited at this time to patients with a malignant neoplasm. Terminal states are difficult to prognosticate, even for cancer patients, and exceedingly difficult for other diagnostic groupings. The National Hospice Organization (NHO) defines terminal as six months life expectancy. The preliminary data from the HCFA waiver project indicates that 76.6% of the patients expired within one to seventy days. The hospice legislation pending before Congress, HR 5180, defines a terminal state as 360 days.

Question 73. How many patients have participated in the Los Angeles (Wadsworth) program? What is the average length of particiation? What is the average daily cost? Has the program been successful there?

Answer 73. During the period FY 1980 through FY 1981, a total of 130 patients were admitted to the Inpatient Unit and 137 patients to the Home Care Unit. A total of 111 patients expired during their stay on the inpatient unit and 18 died at home. The average length of stay on the Inpatient Unit was 64.3 days and 101.8 days in the Home Care Unit. The average daily cost in the Inpatient Unit was $166.96 and $17.63 in the Home Care Unit. For FY 1982, the staff is concentrating their efforts to increase the number of patients admitted to the program by reducing the length of stay in the Inpatient Unit by discharges to the Home Care Unit.

Question 74A. Does the VA have any plans to expand the current hospice program to meet the needs of aging veterans?

Answer 74A. Sixty-one percent of the patients with a diagnosis of a malignant neoplasm were age 55 years or older in the VA medical centers in 1981. The average age was 61.8 years for these patients. In June, 1982, a Chief Medical Director's Letter (IL 10-82-23) was issued in which Medical Centers were encouraged to develop a comprehensive palliative care program.

Question 74B. If the program were expanded, what would be the likely utilization as compared with current services provided to the same patients?

Answer 74B. Our data indicate that 90.2 percent of the patients with a malignant neoplasm are discharged from the hospital in ninety days or less. Patients electing palliative care could possibly be discharged from the hospital in a shorter period of time. Studies indicate that pain and symptoms can be controlled in fourteen days in an inpatient setting. While we do not have enough experience in inpatient hospice care, it is likely that utilization of these services will increase systemwide. It is imperative, however, that the ability to provide home health services be made available in order to discharge patients from inpatient care.

Question 74C. Would such an expansion be cost effective?

Answer 74C. The answer is unclear at present. Because of the labor intensive nature of hospice care which impacts upon the costs of the program, most inpatient units are generally small (5 to 10 beds), with 80% of the hospice workload being maintained in the home care unit. The Wadsworth Palliative Treatment Program is collecting, as part of their evaluation, cost data for their program and the costs associated with current medical interventions. This report will be available late in 1983. The HCFA hospice demonstration project is also collecting cost data which is scheduled to be available in 1983. Additionally, the Congressional Budget Office recently issued a report on the estimated cost savings for HR 5180, which would expand Medicare coverage to include hospice inpatient and home care as a reimbursable service.

Question 75. Has the VA explored the possibility of providing or paying for hospice care on a home care model as well as a hospital model?

Answer 75. All 30 of the HBHC Programs provide care to patients with a malignant neoplasm. Twenty percent of an average daily census of 1,500 have a terminal malignancy for whom the hospice philosophy of care is provided in the home. Where a HBHC Program does not exist, certified community home health agencies may participate in the palliative care plan in the patient's home on a fee for service basis.

Question 76A. In FY 1980, the VA Adult Day Care Program treated a total of 225 adults in three VA medical centers.

What are the goals of the VA Adult Day Care Program?

Answer 76A. The goals are to provide a setting in which aging veterans can obtain continuing rehabilitation, nursing care, screenint and monitoring, information and referral services, counseling and social recreational support services on an outpatient basis. An advantage is socialization, i.e., sharing of common experiences and problems with peers of similar ages.

Further objectives include shortening length of hospital stays, facilitating return to their homes, lessening of caretaker responsibility for family, and prevention of unnecessary institutionalization.

A related program providing day care to older veterans is the VA's Psychiatric Day Treatment Program. Each of the 57 day treatment centers provides treatment to a significant number of geriatric patients. During FY 1981, over 25,639 patients made over 527,000 visits. Fifty percent of these patients were over the age of 52 in 1978. The number of aged veterans continues to increase. DTCs have made special adaptations within their overall programs such as adjusted schedules, group therapy based on age and special reminiscence groups for the aged patient. The goals of these efforts have been to improve health delivery to aging veterans both psychiatrically and physically.

Question 76B. Has the current program achieved these goals?

Answer 76B. The current programs are meeting the objectives to varying degrees depending on their scope, number of staff, and number of times per week the programs are in operation. In regard to the Day Treatment Centers, an empirical study, while not age specific, measured the effectiveness of overall patient treatment in respect to seven treatment goal areas. Significant improvement was reported for all except one of the treatment areas. Over 600 Day Treatment Centers were included in the study.

Question 76C. What is the current status of the Adult Day Care Program?

Answer 76C. The number of known Adult Day Care programs has increased from three to five, and three more are in the developmental process. One of the programs has moved from its previous location within a VA medical center to a community site at a veterans' organization post and has been licensed as a State Adult Day Health Center. Considerable interest has been shown in development of such programs at a number of other VA medical centers.

Question 76D. Are there any plans to expand this program to meet the needs of the aging veteran?

Answer 76D. As management and staff at VA medical centers study the need for alternatives to institutional care for aging veterans, some may decide to develop adult day care programs within their existing resources. Concurrently, at some VA sites consideration is being given to utilizing existing community adult day care programs as referral points. In some cases, veterans would have to defray the costs or, in some instances, a fee basis payment approach could be used for specific care such as therapy or nursing care. Other approaches that are being studied include the development of collaborative programs with veterans' organization posts similar to the one model now in operation.

Question 76E. If the program were expanded, what would be the likely utilization, as compared with current services provided?

Answer 76E. Expansion of the program would be based on an assessment of need at the local level in relation to the availability of other alternatives for these patients, and in relationship to the need for other VA health care resources. We would expect that, if expanded, the program would be fully utilized. With respect to psychiatric geriatric adult day care, because of the large increase of aging veterans projected, such programs would fill to capacity almost as soon as they are developed. The primary effect would probably be on the inpatient demand since one of the goals of such programs is to obviate or delay the need for hospitalization. As the day treatment programs are already over recommended capacity, very little effect would be expected unless there were a very large expansion of new programs.

Question 76F. Would such an expansion be cost-effective?

Answer 76F. Cost effectiveness would be one of the criteria examined when considering expansion of Day Care programs. Of course, the impact on patient care would be a primary factor as well.

Question 77. Is the Day Care Program obviating the need for certain hospital treatment for veterans?

Answer 77. Yes. The need for hospital bed care may be obviated or delayed; however, such a decision has to be individually determined based on the needs of each veteran. A controlled study is required. From the perspective of psychiatric day treatment, individual studies have consistently reflected fewer hospitalizations in psychiatric patients as a result of participation in the Day Treatment Center Program. It is probable, but cannot be affirmed, that a free standing geriatric day care center would reflect similar trends.

Question 78. With respect to the Medical District Initiated Program Planning (MEDIPP) process, are the assumptions upon which utilization is to be projected going to be based on information from the VA Central Office or from the local station?

Answer 78. The MEDIPP process will utilize information from both VACO and local VAMC's to project utilization of health care resources. A comprehensive review process allows opportunities for local, district, regional and CO program officials' comments, analyses and directives for strategic planning on a national basis.

Question 79A. How will MEDIPP effect planning for aging veterans?

Answer 79A. The models used in the MEDIPP needs assessment projections consider the impact of the changing age structure of the veteran population on the demand for health care.

Question 79B. Will overall projections and conclusions from the VA Central Office take precedence over the local estimates of need?

Answer 79B. No. The MEDIPP process ensures grass root planning based on local projected estimates of need. The Medical District Boards and councils deal with the projections of need on a district wide level and reach consensus as to effective resource requirements.

VACO program officials will offer guidance and direction to proprosed recommendations submitted from the medical districts. Appropriate Central Office officials will submit recommendations to the Central Office Planning Board which will ensure that a plan reflecting a balance between local needs and national priorities is recommended to the Chief Medical Director for approval.

Question 80A. I understand that it is hoped that the MEDIPP process will help the VA effectively allocate its resources in the coming years, as its World War II population grows older, and demographic changes alter usage of the present system. Please outline, for the Committee, the assumptions that are being used in conjunction with the MEDIPP process.

Answer 80A. District plans will allow for situational analyses for both current and projected time frames and resource needs. By design, the information requested encourages local identification of relevant, significant issues that need to be addressed. The assumptions for MEDIPP are attached.

Question 80B1. Are the changed needs of elderly veterans being taken into account?

Answer 80B1. Yes. Study findings on the Aged Veteran and projected estimated needs for health care resources are the common frame of reference for the local hospital, District Planning Boards and Central Office officials.

Question 80B2. Are demographic changes, such as continued sunbelt migration, being taken into account?

Answer 80B2. Yes. Demographic changes are being taken into account and will provide significant objective data on which critical decisions will depend. Included, but not limited to, are the following data sources:

Economic Forces: Employment/Unemployment Factors

Migration: (in/our) state patterns, population
shifts to the sunbelt, are rich areas

Geographics:
climate, terrain, transportation accessibility, distance between potential clients and health care delivery services available

Population:
civilian/veteran
male/female
age distribution/projections

Social Forces:
consumerism
family support units
marital status

Question 80B3. Are changes in private pension plans, and Medicare and Medicaid revisions, which may cause increased utilization of VA health-care services by aging veterans, being taken into account?

Answer 80B3. Recents events affecting the Medicare/Medicaid programs have not been incorporated into VA's plans. Future updates of this plan, however, will incorporate such occurrences as more experience is collected on them.

Question 80C. Is the VA Central Office standardizing these assumptions so that need can be measured accurately throughout the system?

Answer 80C. Standards are being developed in order to permit objective evaluation and analysis. Flexibility and opportunity to ensure grass roots input has been incorporated.

ASSUMPTIONS TO GUIDE THE MEDIPP PROCESS

- The independence and vitality of the Department of Medicine and Surgery as a separate system of health care and medical services for veterans will be maintained.

- The Department will continue to provide a full continuum of care for eligible veteran patients.

- The Department will limit its role in health care to eligible patients in accordance with current statutes.

- The current administration's goals to control federal spending and reduce the presence of government will continue.

- Health care costs will continue to rise at a rate above the general rate of inflation; the budget of the Department of Medicine and Surgery will increase no faster than the general rate of inflation.

- A federal mandatory cost containment program will be in effect requiring the system to test alternative models of extending care to remain within resources.

- Efficiency, economy, and productivity will be increasingly rewarded in the budgetary process

- Implementation of plans for new Department of Medicine and Surgery programs or program growth will be dependent upon redirection of priorities, and elimination of the least productive program activities.

- District planning will deal with all aspects of the Department's activities: Patient care, Research and Education.

- MEDIPP will incorporate all resources and facilities planning.

- The patients for whom the VA provides care will include increasing numbers of elderly individuals with both acute and chronic diseases and disabilities. A balance among hospital, extended care and outpatient capability will be available in each Medical District for the optimal care of such patients.

- There will be no major breakthroughs in treatment to change significantly the evolving patterns of morbidity and mortality.

- In order to provide care effectively, facilities will need to utilize new and advanced health care technology as appropriate. As technologic breakthroughs occur, new diagnostic and therapeutic modalities will be made available to veteran patients as promptly as possible, consistent with safety, quality and budgetary considerations.

- Planning for selected programs which have unusual technical, budgetary and political impact such as organ transplantation, spinal cord injury, and geriatric programs, will require special Central Office participation.

- The Department of Medicine and Surgery will fulfill its mission more efficiently in the future by acquiring and applying automation and computer technology for clinical and administrative applications. Expenditures for ADP related products and services will continue to be closely scrutinized within the Agency, by OMB and by Congress.

- MEDIPP will recognize Executive and Legislative mandates and directions, Federal and local regulations, and criteria for generally accepted professional and administrative recognition (e.g. JCAH). However, recommendations to change these constraints will be recognized as a basis for proposing desirable changes.

- There will be no national health insurance program during this period.

- Delegations of personnel management authority from OPM and within VA to Regional and Medical Center Directors will lead to increasing demands from employees for changes in working conditions, compensation, performance evaluation, rewards and mobility requirements.

- Contracting out of commercial-industrial activities (OMB Circular A-76) will be used as a management tool to the extent it facilitates the Department's mission.

- Delivery of services by the Department of Medicine and Surgery will remain under the close scrutiny of Congress, OMB, Veterans Organizations, private sector medicine, health professionals education institutions and other interested parties.

- Approved district plans will be incorporated into ACMD program plans for inclusion in the Department's budget. Because the budget is subject to several reviews and revisions prior to appropriation by Congress, the approval of a district plan does not automatically guarantee the later availability of resources.

Question 81. How are elderly veteran patients, who have chronic alcohol problems in addition to other chronic problems of aging, identified in the VA health-care system?

Answer 81. The identification and clinical care of elderly veteran patients, who have chronic alcohol problems in addition to other chronic problems of aging, begins with the medical examination which is completed at the time of admission. A history of drinking problems, particularly with late onset of abusive drinking, is often correlated with the stresses of aging (e.g. retirement, widowhood, poor health).

Symptomatic or abusive use of alcoholic beverages, particularly when associated with other alcohol related diseases, is a basis for referral to the specialized alcoholism program for consultation, preventive education and treatment of the alcohol problem.

Additionally, evidence of episodic alcohol abuse behavior during the course of VA provided medical care is another signal for referral for specialized consultation on the alcohol problem.

It has been estimated that between 2% and 10% of individuals over age 60 suffer from alcoholism. It is probably one of the five biggest health problems among the aged. It is the most serious of all drug abuse problems among the aged.

Alcohol abuse by elderly persons may be overlooked because the effects of alcoholism on intellectual processes may be attributed to advancing age. Alcoholism is especially detrimental to older persons because 1) their blood levels of ethanol are higher than those in younger persons, and brain neurons may be more sensitive to the drug; 2) ethanol can disturb their sleep and sexual performance; 3) their cognitive functions may be significantly impaired by ethanol; and 4) for elderly patients, who commonly take a variety of drugs, ethanol and drug interactions are particularly hazardous.

The VA has placed special emphasis on the alcohol-related health problems of aging veterans. Treatment interventions are actively underway at the VA's extended care programs, for recognition and clinical management of these important threats to veterans' health.

Question 82. How is the VA addressing the needs of elderly patients who are developing alcoholism as a reaction to aging and life problems, and planning to meet the needs of increasing numbers of these patients?

Answer 82. The VA currently makes no special effort for addressing the needs of elderly alcoholic patients other than the programs in place for all veterans. We encourage alcohol treatment programs within our domiciliaries which affect an increasingly older population. However, increased research attention is being paid to the special problems of the aging alcoholic and to determining the differences and similarities between certain types of brain disease, particularly the distinction between Korsakoff's syndrome and Alzheimer's disease. Additionally, the nutritional needs of aging patients differ from their younger counterparts and the age specific nutritional defects caused by alcoholism need to be further investigated.

Question 83. Should any pilot program which might be developed to link VA geriatric care to community based organization include preventative and rehabilitation programs for aging veterans with alcohol dependence?

Answer 83. Yes. With the increasing recognition of the numbers of aging veterans with developing alcoholism dependency problems, the VA should use its knowledge and experience with alcoholism treatment and rehabilitation to insure that programs linking the VA and community based organizations include relevant alcoholism care programs.

Question 84. What percentage of the total VA research budget is now allocated for aging projects?

Answer 84. In fiscal year 1982 the VA Research and Development Office expended approximately 6% of the total VA research budget for aging related projects.

Question 85. Is the majority of research on aging taking place at the GRECCs or is research on aging taking place throughout the VA system?

Answer 85. Research on aging is taking place throughout the VA system. In fiscal year 1982 the Research and Development Office expended approximatly $7,700,000 for the conduct of aging related research. Of this total amount, 23 percent is expended in GRECCs and the remainder is utilized by research scientists not associated with a GRECC.

Question 86. The VA Medical Research Service does not currently solicit specific research on aging. Will this practice be changed in the future? In what ways?

Answer 86. There are no current plans to specially solicit research studies on aging. The Research and Development Office annually examines areas that offer the greatest potential for focused solicitations.

Question 87A. Will aging projects receive a larger share of the VA budget in the future?

Answer 87A. It is expected that the budget for VA research in aging will increase modestly in the near future as aging patients seek more care in VA hospitals. As clinicians confront the health related problems of the aging veteran, their research efforts will reflect these issues.

Question 87B. How is the allocation of funds for research projects determined?

Answer 87B. Within broad program categories (e.g., Merit Review, Career Development Cooperative Studies) the allocation of funds for research is based on the quality of the research studies submitted. In a few areas where there are both a concentration of VA patients and where national experts have advised the VA that a special research opportunity exists, solicitation of focused research studies has been carried out. Examples of such areas are studies of the basic biological mechanisms underlying schizophrenia and alcoholism.

Question 87C. Is it by relevance to the needs of VA patients?

Answer 87C. Relevance to the needs of VA patients plays an important role in identifying areas of special research attention. However, not all areas of relevance are equally suited to special research initiatives.

Question 88. What are the VA's present plans for use and expansion of the GRECC programs over the next ten years?

Answer 88. Because of budget constraints, current plans call for enhancement of the eight existing GRECCS, with no expansion in their number. At present, enhancement consists of additional FTEE for an Evaluation/Education Coordinator at each GRECC, and $200,000 for development and delivery of continuing geriatric education for VA clinical care staff. These latter education programs will be offered throughout the VA system.

Question 89A. How have GRECC activities and research to date benefited aging veteran patients treated in VA hospitals?

Answer 89A. Six of the eight GRECCs operate limited clinical demonstration units, the intent of which is to develop, evaluate, and refine "state of the art" treatment for aging veterans. As such, the GRECCs' major long-term impact will derive from their developing treatment strategies that may be propagated throughout the VA system. Examples include the development of 1) hospital admission criteria and assessment protocol for aged veterans, 2) standards of care for patients with dementia resulting from Alzheimer's disease and related disorders, and 3) innovative outpatient programs designed to reduce aging veterans' need for hospitalization and institutional care.

Within this broad context, the GRECCs also have a more limited, short-term impact on veteran care. For example, during FY 1981 GRECC staff treated and/or provided consultation to more than 3600 inpatients; this represents approximately 5% of the aged veterans treated in VAMCs during that year. This impact may be presumed to increase with the addition of GRECC inpatient units at Minneapolis and Palo Alto during the current fiscal year.

Question 89B. What mechanisms have been developed to ensure that what is learned in GRECCs is exported to the VA hospitals?

Answer 89B. Education represents a major and significant goal in the GRECC mission. The GRECCs are expected to develop information that will improve the quality of care to elderly veterans and to share this information with other VA and non-VA health care providers. There are several mechanisms by which this information is disseminated: 1) a quarterly GRECC newsletter that is distributed throughout the VA system; 2) on-site training in geriatrics for staff, physician fellows, and students in allied health professions with diffusion of information as trainees return to or move into other VA and non-VA health care facilities; 3) local, regional and national lectures, workshops and conferences, produced by the GRECCs in conjunction with Regional Medical Education Centers, affiliated academic programs, and various geriatric consortia; and 4) the publication of research in professional journals and its occasional citation in newsletters and in the public media.

Question 90. To what extent has GRECC research been specifically targeted to improving health care delivery within the VA system as opposed to more general biomedical research similar to that which is often performed in medical schools and teaching hospitals?

Answer 90. Approximately 26% of GRECC research during FY 1981 was clinical or health services (HSR&D) in nature. With the development of HSR&D Field Programs by the Research and Development Office, there will be greater support for GRECCs conducting this kind of research. The need for GRECCs to be doing more health services and clinical research is recognized.

Question 91. Have the GRECCs performed any research to develop methods to assess long-term care patients' needs and to help identify the most appropriate level of care for each patient?

Answer 91. This type of question is being addressed by staff at the Alzheimer's Dementia Unit, Seattle/American Lake GRECC. Experience there has reinforced the notion that institutional care is neither necessary, cost-effective, nor desirable, except in very advanced cases, for the treatment of Alzheimer's Disease and related disorders.

Question 92. A great deal of research done at the GRECCs has focused on senile dementia. Has this research been used to develop plans over the next two decades?

Answer 92. As described above, work at the Seattle/American Lake GRECC bears directly on this issue. In a broader context, the Office of Geriatrics and Extended Care is working with individuals from the GRECCs, Bronx VAMC, and the Kellogg Foundation to help develop patient care standards for treating veterans with dementia.

Question 93. Do research institutions like the GRECCs exist in the private sector?

Answer 93. Certainly, there are numerous gerontological research centers, many within academia, across the country. None of these, however, have the clinical care facilities and resources, nor the numbers of patients with like diagnoses, that the GRECCs have within the VA system.

Question 94A. What efforts have been made to disseminate research results to practitioners in non-GRECC VA medical centers?

Answer 94A. Currently, several GRECCs are developing educational programs with the various Regional Medical Education Centers (RMECs) that will be delivered, through various educational models, to VAMCs throughout the respective GRECCs medical regions. The programs will focus on topics such as nutrition, incontinence, assessment of dementia, depression, and others based on local VAMC's needs assessments. The response to question 89.B. also bears on this question.

Question 94B. To what degree have these dissemination efforts been successful?

Answer 94B. This question cannot be definitively answered. During the current fiscal year the GRECCs were awarded FTEE for a full-time Evaluation/Education Coordinator. With the addition of this professional position, we will be better able to assess and compile information concerning the impact and effectiveness of GRECC education programs.

Question 95. How has the GRECC research been integrated and/or coordinated with that of the National Institute on Aging and other research units?

Answer 95. In August 1981 the Department of Medicine and Surgery hosted a conference for the purpose of defining a research strategy with regard to Alzheimer's Disease and related disorders. The National Institute on Aging, National Institutes for Health, and GRECCs were participants in this conference. Every effort is made to assure that GRECC research does not unnecessarily duplicate the work sponsored by other government agencies, private corporations and foundations.

Question 96. What is the current status of the VA geriatric fellowship program for medical doctors?

Answer 96. The VA physician Geriatric Fellowship Program has been in existence for four years and has just begun to operate at full capacity. As of July 1, 1982, 44 clinical Fellows are participating in this special program at 12 VA medical centers. So far, 36 physicians have completed the required two years of Geriatric training; 19 more are scheduled to graduate next year, bringing the total of trained specialists to 55 by June 1983.

Question 97. I understand that the VA also sponsors a masters degree program for nurses in gerontology and a program for gerontologist dentists. In FY 1982, what was the level of participation?

Answer 97. During FY 1981-82, the VA sponsored 29 masters degree level clinical nurse specialist trainees in geriatrics/gerontology at a cost of $44,000. In July 1982, the VA initiated a special Fellowship Program in Geriatric Dentistry and five Fellows are now participating. The estimated cost in FY 1982-83 is expected to amount to $239,469.

Question 98A. What are the VA's gerontology and geriatric staffing needs for the next 10 years?

Answer 98A. The exact gerontology and geriatric staffing needs for the next ten years cannot be determined at this time. However, the aging veteran is a reality that has been recognized by VA planners for some time. Specifically, the Offices of Geriatrics and Extended Care, Professional Services, and Academic Affairs as well as MEDIPP, the Management Systems Service and other VA components have been planning for present and future needs in this area, including staffing. It must be noted that while the percentage of total veterans who are over 65 was only 11% in 1981, this group accounted for 25-30% of veterans hospitalized in VA medical centers. It is anticipated that the elderly will comprise a steadily growing percentage over the next decade. At the same time, the skills and services necessary for their care exist at all VA medical centers presently providing care. However, it is felt that better coordination of services will be necessary in the future to provide the most effective care to growing numbers. Specially trained health care providers, such as physicians, nurses and dentists, will be necessary to provide consultation for complex cases, education for other providers, leadership of interdisciplinary teams and "hands-on" care for selected populations.

Question 98B. What efforts are being made to meet those needs?

Answer 98B. The VA has long recognized the need for specially trained persons in the system to provide care for the elderly. The Geriatric Fellowship program is in its fifth year with 36 geriatricians trained to date. A training program for gerontologic dentists was recently begun, reflecting the awareness of the role of oral health in the overall nutrition, quality of life and medical status of the elderly person. Master's level gerontologic clinical nurse specialist positions are also supported by the VA.

Besides specialist training, a wide variety of health care workers who function in more general areas have received brief periods of training through special conferences and workshops on aging sponsored by the RMECs (Regional Medical Education Centers), the Dental Education Center and the GRECCs and through contact with the Interdisciplinary Team Training in Geriatrics and the Geriatric Evaluation Units which have been set up at several VA medical centers.

Recognition of the need for special focus on the problems of geriatric patients was given by VACO in the establishment of the Liaison Coordinating Committee for Geriatrics and the CMD's Geriatrics Steering Committee.

Question 99. How have the GRECCs served as resources for other educational units in the VA, i.e., Regional Medical Education Centers, Learning Resource Centers, and Comprehensive Health Education Programs?

Answer 99. Several GRECCs have developed training/education programs in collaboration with RMECs, LRCS and CHEPS, with GRECC staff acting as "content experts" and the education field program staff acting as "educational process experts". To date, this collaboration has worked most effectively where these programs are geographically proximate, i.e. Minneapolis, St. Louis, and Los Angeles (Wadsworth and Sepulveda).

Question 100. To what degree have geriatric fellows and other health professionals who have received geriatric training remained in the VA as clinicians and teachers?

Answer 100. Of the groups of Geriatric Fellows completing two years of special training, 77 percent remained in the VA system in FY 80-81 and 75 percent in FY 81-82. Nearly all of these retained Fellowship program graduates now provide direct patient care in Geriatric sections of Medical Services in VA medical centers or through consultations to other services. These physicians also hold part-time academic appointments at medical schools affiliated with the VA and are teaching medical students, residents, and other staff. Two of the VA Geriatric Fellowship Program graduates were awarded Geriatric Medicine Academic Awards by the National Institute on Aging, in May 1982, for the specific purpose of developing a curriculum in Geriatrics for the training of medical students and physicians at all levels.

Question 101. Since the GRECC centers have been located at VA medical centers affiliated with medical schools, to what degree can we expect to see improvement in geriatric health care that VA patients are receiving in the principal places one finds elderly patients - nursing homes, domiciliaries, extended care beds - many of which are in facilities unaffiliated with medical schools.

Answer 101. These improvements are presently effected through continuing education. For example, the Sepulveda GRECC is currently working with the Southwest RMEC in developing a program to teach nursing home staff new techniques in dealing with incontinent patients. Similarly, the St. Louis GRECC is working with the South Central RMEC to develop education programs for unaffiliated VAMCs in that medical region.

Question 102. Has the quality of care rendered to veterans in geriatric centers or other affiliated VA medical centers been changed as a result of the GRECC program?

Answer 102. The presence of GRECC clinical units and Geriatric Evaluation Units in other VAMCs has had a positive impact on quality of care to elderly veterans. This conclusion is based on research which indicates that patients are better diagnosed and less medicated when treated by geriatric specialists. In addition, the Sepulveda GRECC has published research on one of their programs that shows a positive impact on physician attitudes toward treatment of geriatric patients.

Question 103A. How are GRECC funds allocated between research, education and clinical activities?

Answer 103A. The allocation varies between program components and from Center to Center. This is due to the fact that funding comes from several sources and cost centers. For example, research funding comes from both VA and non-VA sources, usually on the basis of merit review; education programs and initiatives are funded through the Office of Academic Affairs and depends, in part, on the kinds of geriatric education programs (e.g. Geriatric Fellowship, Interdisciplinary Team Training in Geriatrics) that are funded for the host facility; clinical activities are funded through the VA medical center medical care appropriation.

Question 103B. How are staff and support allocated among the three areas?

Answer 103B. As above.

Question 103C. Do these allocations vary among the 8 existing GRECCs?

Answer 103C. Yes.

Question 104A. To what extent is there consideration and communication among the eight existing GRECCs?

Answer 104A. The GRECC directors meet twice annually with Central Office staff for the purpose of facilitating communication and coordinating activities. These meetings are supplemented by frequent contacts by Central Office and communication among GRECC staff concerning areas of professional and scientific interest. Currently, work is proceeding on the development of an interactive, computer information system that will greatly enhance the GRECCs' capability for communication and information exchange.

Question 104B. Does the VA Central Office direct that coordination and communication?

Answer 104B. The Central Office staff attempt to facilitate communication among the GRECCs. This is accomplished by providing both resources for and an environment in which productive communication can occur. Providing travel funds for meetings and developing an information system are examples of these resources.

Question 105. To what extent do VA medical school affiliations, which traditionally encourage research and administration of acute, tertiary care, help the VA's efforts to administer care to its growing aging veteran population?

Answer 105. The medical schools of the nation are beginning to recognize the far-reaching impact on the health care system by the ever increasing segment of elderly in the U.S. population. Although plans to integrate geriatric information into the curriculum have been slow to emerge, the medical schools are gradually supporting the geriatric training initiated by the VA in 1978. Medical student and resident rotations through the VA Physician Geriatric Fellowship Programs are increasing.

Question 106A. How would increased emphasis on geriatrics within the system affect the VA's present medical school affiliations?

Answer 106A. Increased emphasis on geriatrics within the VA system would be regarded as a positive step by our affiliated medical schools, providing there are no transfers of substantial budgeted resources from acute care for geriatric purposes.

Question 106B. Will the affiliations be weakened if there is less emphasis placed on acute, tertiary care as the veteran population ages?

Answer 106B. Since the health needs of elderly veterans are often greater for acute care than for long-term care, the traditional emphasis on acute care should not be diminished. At the same time, however, awareness of the different requirements for the treatment of elderly acute cases is essential.

Question 107. How much VA manpower is desirable and necessary to provide cost-effective quality care for elderly veterans as well as for teaching and research in geriatrics?

Answer 107. Current VA planning is for a comprehensive and integrated health care delivery system for the care of all veterans, therefore, a separate plan for elderly veterans is not being developed. The first submission of MEDIPP plans in November 1982 will provide a basis for developing resource levels that are desirable and levels that are necessary for all VA health care programs.

Question 108A. What configurations of geriatric personnel are necessary to provide cost effective, quality care for elderly veterans?

Answer 108A. There is no formula for teams of health care personnel to provide satisfactory care for all elderly persons. The types of people needed will depend on availability of trained persons in gerontology and/or geriatrics, experience and interest of persons who have been providing care at any given location, the demographics of the area, existing technology, community resources and academic affiliations. However, there appears to be general acceptance that the team approach will provide the most efficient utilization of the myriad personnel needed by elderly patients and result in improved patient management. Interdisciplinary Team Training in Geriatrics is being developed by the VA to establish a cadre of professionals with the skills and knowledge necessary to meet the wide spectrum of health care needs of the geriatric patient. These care-oriented teams represent a variety of health disciplines (e.g. medicine, nursing, social work, physical and occupational therapy, psychology, etc.) and provide a ripple effect through the health care community by education of students and professionals rotating through positions on the team and with didactic programs.

Question 108B. Can these configurations be achieved by redirecting current personnel, or are more specially trained health professionals needed?

Answer 108B. Obviously necessary services are currently being provided to the 25% of hospitalized veterans who are over 65. However, as this percentage increases and as more health care personnel with special training and expertise become available both within and outside the VA, all VA medical centers would benefit from the participation of health professionals with knowledge of the normal aging process and the interactions of this process with illnesses and the social derangements experienced by the elderly. Therefore, specialists are being trained and will continue to be trained and subsequently hired by VA medical centers to improve the effectiveness and cohesiveness of "teams" of care-givers. It is inevitable, too, that generalists in internal medicine, nursing, social work, dentistry, nutrition, and rehabilitation will be redirected by their own interests and self-initiated education or by the needs of their medical centers to care primarily for the elderly. It is important to realize, however, that the quantity and complexity of the problems affecting the elderly not only require involvement of a wide variety of disciplines, but often require more time from each practitioner. The elderly move more slowly, respond to interventions more slowly and mend more slowly than younger patients. They experience ongoing needs of their chronic medical problems as well as acute episodes. It has been estimated by some medical assistance and medicare studies in ambulatory care that a visit for an over-65 patient takes 8-16% longer than the average for patients under 65. Therefore, as the patient population ages, more personnel will be required as well as different kinds of personnel.

Question 108C. How should the desired types of people be trained?

Answer 108C. There is no consensus of opinion on the ideal way for gerontologic/geriatric specialists to be trained. Some will be self-trained through reading, attendance at conferences and professional experiences. Some will be trained on-the-job as members of teams to which they bring more general skills. Others will be trained in academically oriented fellowship or degree programs, such as those available to physicians, dentists, nurses, and long term care administrators, to name a few. The VA and the community must share in this endeavor because the VA represents only an intense subset in the entire population which is steadily aging. The VA will benefit both from professionals trained within the system, who bring a special understanding of those problems which are unique to veterans, and from those outside the system, who bring fresh insights to universal concerns.

Question 108D. What role should geriatricians play?

Answer 108D. While geriatricians will provide "hands-on" care in some geriatric units, their most valuable role will be to provide coordination, consultation and leadership at the medical center and to serve as a resource to the district and region in education and planning. Some geriatricians will also play a prominent role in both basic and health systems research related to aging.

Question 109. Are the knowledge, attitudes, and skills specifically associated with geriatrics adequate to designate the field as a separate discipline?

Answer 109. The knowledge, attitudes, and skills associated with Geriatrics are definitely sufficient to designate the field as a separate discipline. Nevertheless, this issue is still rather controversial because there is no agreement whether (1) Geriatrics should be recognized as a special area within internal medicine or (2) the differences are great enough to encourage the development of a separate specialty.

Question 110. Are there any planned re-training efforts for current VA health-care professionals so that they may respond to increasing chronic health-care needs?

Answer 110. Ongoing re-training and refresher training to enhance the skills of current VA health-care professionals in geriatrics and chronic health-care needs is offered through a large variety of continuing education programs. As of June 1982, $245,184 has been spent by the VA Department of Medicine & Surgery for such training in FY 82. (Comparable hard data for FY 81 are not available.)

Geriatric training for physicians, dentists, nurses, therapists, psychologists, and other associate health personnel was offered through Continuing Education Field Units (CEFU's) and reached 4,738 health-care staff so far in FY 82. These CEFU's comprise 7 Regional Medical Education Centers (RMEC's), 8 Cooperative Health Education Manpower Centers (CHEP's), and 2 Dental Education Centers (DEC's). Further geriatric training is scheduled for the remainder of FY 82 on such topics as Nutrition, Functional Assessment, Sensory Changes, Exercise and the Aging Motor System, Psychological changes, and many more.

For FY 83, special education programs in geriatrics/gerontology are being developed by the VA Geriatric Research Education and Clinical Centers (GRECC's) at L.A. Wadsworth and Sepulveda, CA, jointly with the Southwest Regional Medical Education Center (RMEC) for every VA medical center in their region. All eight GRECC's are currently preparing proposals (that are subject to merit review) for conducting similar programs in their medical regions. These forthcoming geriatric educational efforts will be funded by a $200,000 grant from the VA Office of Academic Affairs.

Question 111. Has current VA student and resident training been redirected to include training in geriatric care?

Answer 111. The VA Geriatric Fellowship Program is training physicians to become not only proficient in geriatric clinical care but also to become leaders in Geriatric medicine and Gerontology for the VA and also for the nation. To date, 36 Geriatric Fellows have completed the program, and 19 more are expected to bring the cummulative total of Geriatric specialists to 55 in June 1983. Of these graduates, about 77 percent are retained in the VA system (see Reply to Question 100). Most are active as Chiefs of Geriatric Sections and also as teachers to medical students and residents through concomitant part-time academic appointments at medical schools affiliated with VA medical centers. Those VA Fellows who became full-time professors at medical schools are now teaching Geriatrics/Gerontology in elective and selective courses. Two former VA Geriatric Fellows are currently developing specific Geriatric curricula at the University of Alabama and University of Wisconsin medical schools with grants from the National Institute of Aging.

In addition, a new Fellowship Program in Geriatric Dentistry was initiated in July 1982 for the purpose of preparing dentists for clinical excellence in dental geriatrics for inpatient, ambulatory and long-term care VA facilities. Senior Fellows and graduates of this program are also expected to teach students and residents. Student training and redirected training of the associated health professions has been addressed in replies to questions 97, 98B, and 110.

Just recently, 39 Geriatric residency positions were allocated to VA medical centers for AY 82-83. These positions are designated for Geriatric experiences in the VA health care system.

Question 112. What support from the VA Central Office is being given to aid individual VAMC education efforts in geriatric care?

Answer 112. VA Central Office has supported a variety of Geriatric education efforts at VA medical centers as follows:

(a) Interdisciplinary Team Training in Geriatrics at 5 sites; funding amounted to $211,105 in FY 81 and $375,335 in FY 82. (Four additional sites are expected to be in operation by FY 84.)

(b) VA Physician Geriatric Fellowship Programs at 12 sites, the funding provided amounted to $1,475,300 in FY 81 and to $1,648,700 in FY 82.

(c) VA Fellowship Programs in Geriatric Dentistry at 5 sites. This new program began operating in July 1982, and the estimated cost amounts to $239,469 for FY 83.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1A. **If in 1990 and 2000 the VA were to provide health-care services to the same proportion of veterans over the age of 65 as it does today, what reallocation or expansion of resources would be necessary generally — and specifically in the areas of outpatient care, acute hospital care, intermediate hospital care, hospital-based home care, nursing home care, the residential home care program, geriatric day care, and domiciliary care?**

Answer 1A. **Generally, there probably will be a shift of resources with some expansion required. A determination of the amount of shift and the degree of expansion will be based upon the Medical District Initiated Program Planning process. The following specific impacts will probably be felt:**

a. Outpatient care would continue to be given emphasis and some expansion in the program would be likely.

b. There will continue to be a need for acute care. However, there will be an increased need for extended hospital care as more and more aging persons are treated.

c. Nursing home care would experience the greatest expansion.

d. Domiciliary care, which would represent the minimal level of medical care, would probably be somewhat reduced.

e. The residential home care program, hospital based care, and the geriatric day care program would continue to receive emphasis as alternatives to institutionalization.

Question 1B. What efforts have you made to work with Medicare to discuss possible transfers of funds from the HCFA to the VA for Medicare-eligible veterans to whom the the VA provides care?

Answer 1B. The VA has not discussed with HCFA the transfer of Medicare funds for medical services provided all Medicare-eligible veterans. By agreement with HCFA, the VA bills Medicare when emergency humanitarian care is provided a nonveteran Medicare beneficiary and when an ineligible person, provided care as a presumed veteran and later found ineligible, is known to be a Medicare beneficiary.

Consideration of the VA billing Medicare for Medicare-eligible veterans must be approached with the realization that acceptance of Medicare reimbursements could subject the VA health care system to administrative requirements of HHS. The VA cost accounting system would have to comply with HHS requirements and HHS may insist on conducting retrospective audits of the cost accounting records of individual VA health care facilities. Transfer of funds from Medicare to the VA does not diminish the total budget but it does increase cost to the taxpayer and VA in the form of administrative overhead to establish and maintain billing, processing and collection procedures. With CHAMPVA we now pay an intermediary some $8 to $9 per claim for processing.

Question 2A. The October 1981 VA Health Systems Information Service Report 81-8, The Aged Veteran: Part I, stated that 58 percent of hospital discharges in the year 2000 will be older veterans and that those veterans will probably account for more than 58 percent of available resources. Apparently because older people generally remain in the hospital longer, table three of the report indicates a projected increase of 13.8 percent in discharges in the year 2000 over 1979 and a much greater increase over that same period, 34.6 percent, in the number of hospital patient days and a corresponding utilization of an additional 16,000 beds.

Do you believe that advances in medicine may alter the average length of stay for individuals in the age groups 65-74 and over 75, thus reducing the projected need for an additional 16,000 acute care beds in 2000 over those used in 1979?

Answer 2A. It is unlikely that breakthroughs in medicine will alter length of stay for older patients. While new advances tend to increase life span they do not usually hasten recovery processes. Once in a while, however, new technologies do hasten arriving at a precise diagnosis and thus might shorten length of stay. This was the case with the CAT Scanner. Such experience is the exception rather than the rule.

Question 2B.	If those 16,000 additional acute care beds above the 1979 level were needed in the year 2000, as the report suggests, how much of an expansion of the present system would that require?
Answer 2B.	The Health System Service Information Report, upon which your question is based, was intended only to present an analysis of the impact that the aging veteran population would have on the demand for health services if all other variables were held constant, and if veterans utilized hospital services at the same rate that they use them today. However, other factors affect the demand for health care, such as migration of the veteran population, the diagnostic make-up of the patients being treated, economic and social conditions which cause the rate of utlization to either increase or decrease, and the length of time of patient stay in various bed sections. When these factors and others are considered, a different picture for the year 2000 is obtained. Generally, this picture is that acute care beds will definitely still be necessary. However, the length of time patients stay in the hospital for acute care is still declining for every age group, and it is expected that a further decline will be felt before a "bottoming out" is reached. On the other hand, more than likely there will be need for more extended hospital beds in not only the medicine bed section, but the neurological, psychiatric, and rehabilitative areas. A determination of the degree of shift between acute and extended hospital care

will be determined through the Medical District Initiated Program Planning process and application of national sizing studies.

Question 3.

Obviously over the next 20 years great demands will be placed on almost all areas of health care in the VA. Do you believe that one of these forms of care, for example acute care, should be the first priority in preparing to meet the demand for care, or should a more evenly balanced mix of services, which would result in serving fewer individuals but a wider range of care, be provided.

Answer 3.

The VA provides a full spectrum of health care to veterans it serves. All aspects of its health care system are essential and one element cannot be given priority over another.

Question 4.

Of those veterans over age 65 receiving care at VA facilities, what proportion have resources substantial enough to preclude them from receiving care if they were subject to a means test?

Answer 4.

We have insufficient data on which to base an intelligent estimate of the percentage of veterans over age 65, receiving care at VA facilities, who would have resources to defray the cost of such care.

Question 5A. What is the present occupancy rate of VA nursing homes?

Answer 5A. As of September 30, 1982 the average occupancy rate of VA nursing homes was 93.6%.

Question 5B. What proportion of the demand by eligible veterans for nursing home care through the VA do you estimate the VA is meeting at present?

Answer 5B. The VA is presently meeting approximately 12% to 14% of the demand by eligible veterans for nursing home care through the VA.

Question 5C. What proportion of the demand by eligible veterans for nursing home care through the VA do you anticipate the VA will be able to meet in 1985, 1990, 1995, and 2000?

Answer 5C. There appears to be much more demand for nursing home care than the VA will ever be able to accommodate and still maintain a balance in its allocation of current levels of health care resources. The actual proportion of the demand by eligible veterans for nursing home care that the VA will be able to meet in the future will be dependent on the level of resources provided for VA health care programs and on the planning for effective use of those resources that will be accomplished through our Medical District Initiated Program Planning process.

Question 6A. What standards are used to determine the levels of care—described by the VA as level I through IV—that a nursing home can provide?

Answer 6A. Patients are classified at the most appropriate level of care at a given time. Each level of care (category of care) is defined by the VAMC and includes a set of descriptions which provide guidance in the categorization process. The categories are: Category I - Intensive Nursing Care; Category II - Direct Nursing Care of Lesser Concentration; Category III - Moderate Direct Nursing Care; and Category IV - Minimal Direct Nursing Care.

Question 6B. Please describe the extent to which VA nursing homes and community nursing homes are generally capable of providing each of these levels.

Answer 6B. VA nursing homes have the capability of providing care to 70 percent of patients in Levels I and II and 30 percent of patients in Levels III and IV. Contract homes in the community have the option of either accepting or denying admission of a veteran, depending on their capability to provide the needed services at the authorized per diem rate. We have experienced little difficulty in locating the appropriate level of community nursing home care for most veterans. However, there is more difficulty in placing those veterans who require total care.

Question 7A. Of the veterans receiving nursing home care through the VA, either in VA nursing homes or in contract community nursing homes, what percentage in each type of facility—VA and contract—are service-connected and what percentage are non-service-connected?

Answer 7A. Of the veterans receiving VA nursing home care on the day of the FY 1981 annual census, 35.1 percent were service-connected and 64.9 percent non-service-connected. In contract community nursing homes, 46.9 percent were service-connected and 53.1 percent non-service-connected.

Question 7B. What percentage in each type of facility require care in each of levels I through IV?

Answer 7B. The level of care distribution in VA nursing homes for the period ending March 31, 1982 was: Level I - 30.7 percent; Level II - 38.4 percent; Level III - 25.3 percent; and Level IV - 5.7 percent.

The level of care for Community Nursing Homes is not defined by the four levels used for VA nursing homes. However, VA levels I and II equate approximately to the care provided in skilled nursing facilities, and levels III and IV to the care provided in intermediate care facilities. As of March 31, 1982, the distribution of community nursing home care was as follows: Skilled Facilities - 71 percent; Intermediate Care Facilities - 29 percent.

Question 7C. What percentage of non-service-connected disabled veterans receiving nursing home care through the VA would be eligible for nursing home care under Medicaid?

Answer 7C. It is assumed that, in general, veterans in receipt of VA pensions are eligible for Medicaid in nursing homes in most States since by definition they have little or no income. Pension beneficiaries in VA nursing homes represented 37 percent of that population and 27 percent of the Community Nursing Home population in 1981. Two major factors affect the availability of Medicaid for these veterans in need of nursing home care: a) the availability of Medicaid beds in the community; and b) the willingness and ability of a State to increase its income requirements in line with increases in cost-of-living adjustments for pension beneficiaries.

Question 8A. What factors are taken into consideration in selecting, among the veterans who are seeking and eligible for nursing home care, which ones to place in a VA nursing home?

Answer 8A. The factors that are considered in selecting veterans who seek and are eligible for nursing home care in a VA nursing home are the medical status, the scope of services that will be required, the availability or lack of the needed services in non-VA facilities, and the need for a long term period of specialized restorative services.

Question 8B(i). Please describe whatever priority system you have involving service-connected and non-service-connected considerations for selecting veterans for placement in VA nursing homes and contract nursing homes.

Answer 8B(i). The priority system applied to nursing home care applicants affords the highest priorities to the service-connected veteran. VA Regulation 6049 addresses priorities for admission to nursing home care, as well as admissions to hospital and domiciliary care. To simplify VA Regulation 6049 to areas that are directly applicable to nursing home care, the following priorities were developed and are provided as they pertain to admissions to VA Nursing Home Care and Community Nursing Home Care (CNHC):

Priority 1:

Veteran patients receiving hospital care in VA facilities who require NHC (nursing home care) for a service-connected or adjunct disability and active duty inpatients who require a protracted period of nursing care and will become veterans upon discharge from active military service.

Priority 2:

Veterans not hospitalized by the VA who require NHC for service-connected or adjunct disabilities.

Priority 3:

Veterans with a service-connected disability who are receiving VA hospital care and require NHC for nonservice-connected disabilities.

Priority 4:

Veterans with a service-connected disability not hospitalized by the VA who require NHC for nonservice-connected disabilities. (Not appropriate for CNHC)

Priority 5:

Nonservice-connected veterans receiving VA hospital care who require NHC.

Priority 6:

Nonservice-connected veterans not hospitalized by the VA who require NHC. (Not appropriate for CNHC)

Question 8B(ii).	What assurance do you have that field stations are applying those priorities with relative uniformity?
Answer 8B(ii).	The application of the priority system at field facilities is an area which receives close review. Such services are included in Service Program Visits, SERP, IG, and visits made by various service organizations. The comments provided in these reviews do not cite this area as deficient which indicates that the priority system is being uniformly applied and that field facilities are in compliance with established priority guidelines.
Question 8C.	Please provide a copy of current guidance provided to field stations regarding the selection of patients for admission to VA nursing homes and the discharge of nursing home patients.
Answer 8C.	Copy enclosed.

Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

M-1, Part I
Chapter 12

April 20, 1982

Chapter 12, "Nursing Home Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is revised as indicated below:

NOTE: The purpose of this revision, other then editorial, is to:

a. Redefine authority for outpatient entitlement (par. 12.01c).

b. Define VA Nursing Home Care Unit (par. 12.02b).

c. Define Skilled Nursing Care (par. 12.02c).

d. Define Intermediate Nursing Care (par. 12.02d).

e. Include that veterans may be admitted to a VA Nursing Home Care Unit by direct admission (par. 12.15a).

f. Include priorities for admission (par. 12.11).

g. Provide for maintaining a waiting list for admission to a VA Nursing Home Care Unit (par. 12.18).

h. Change responsibility for equitable availability of VA Nursing Home beds from Regional Medical Director to Medical District Coordinator (par. 12.16c).

i. Provide that application for direct admission to a VA nursing home will be forwarded to Chief, Medical Administration Service (par. 12.17a(1)).

j. Require that waiting lists will be reviewed no less than annually (par. 12.18).

k. Provide for both intermediate and skilled nursing care in community nursing homes (par. 12.27).

l. Include that a veteran may be directly admitted to a community nursing home (par. 12.31a).

m. Allow certain veterans to remain in a community nursing home at VA expense for an indefinite period of time (par. 12.31b).

Pages 12-i and 12-ii and pages 12-1 through 12-12: Remove these pages and substitute pages 12-i and 12-ii and pages 12-1 through 12-13 attached.

RESCISSIONS: II 10-73-35, II 10-74-22, II 10-75-48 and II 10-81-13; and chapter 12, dated June 18, 1973, part I, M-1.

DONALD L. CUSTIS, M.D.
Chief Medical Director

Distribution: RPC: 1117
FD

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RESCISSIONS

The following material is rescinded:

1. COMPLETE RESCISSIONS

a. Manuals

Chapter 12, dated June 18, 1973

b. Interim Issues

10-73-35

10-74-22

10-75-48

10-81-13

CHAPTER 12. NURSING HOME CARE

SECTION I. GENERAL

12.01 BASIC AUTHORITY

a. **VA Nursing Home Care.** VA Regulation 6047.

b. **Community Nursing Home Care.** VA Regulation 6051

c. **Outpatient Care.** Veterans in community nursing homes at VA expense may be entitled to outpatient services, supplies and equipment (including prosthetic and similar appliances) in accordance with VA Regulations 6060, 6115.3 and 6120 through 6123.2. The services, supplies and equipment may be provided only when not normally considered a part of nursing home care at that nursing home, and the nursing home does not customarily furnish them to their nonveteran patients, and such care is not a duplication of those benefits furnished the veterans under nursing home care.

12.02 DEFINITIONS

a. **Nursing Home Care.** This term means the accommodation of convalescents or other persons who are not in need of hospital care, but who require nursing care and related medical services. For veterans in VA Nursing Home Care Units, this includes any professionally recommended services, supplies, and equipment. For veterans in community nursing homes, this includes room, meals, nursing care, physician visits, emergency dental care, medicines and drugs, minimal laboratory and radiology services, and other special services and supplies normally provided patients requiring nursing home care. The term includes either intermediate or skilled nursing home care or both.

b. **VA NHCU (Nursing Home Care Unit).** A specialized nursing facility designed to care for residents who require nursing care and supportive personal care and individual adjustment services. The NHCU may be located in a section of the medical center structure or in a separate building within the medical facility.

c. **Skilled Nursing Home Care.** Care provided in a community nursing home which is prescribed by, or performed under the general direction of, persons duly licensed to provide such care. The facility shall be licensed by the State in which it is located and provide physician, nursing, rehabilitative, dietetic, pharmaceutical, laboratory, radiological, social, and spiritual service to the patient.

d. **ICF (Intermediate Care Facility).** A community nursing home, licensed by the State in which it is located, to provide on a regular basis health care services to individuals who, because of their physical or mental condition, require such care and services, above the level of room and board, as provided in a domiciliary but do not require the intensity or frequency of such services as provided in an SNF (skilled nursing facility). The facility must be certified for participation as a provider of ICF services under Title XIX (State Medicaid Program). If there is no Medicaid program in the State, the ICF must meet the standards for ICFs as outlined in 42 CFR.

e. **Medical Center.** This term, when used in this chapter, applies also to the VA Outpatient Clinics in Honolulu, Hawaii and Anchorage, Alaska.

f. **Clinic Director.** This term, when used in this chapter, also refers to the Chief, Ambulatory Care Service or ACOS/Ambulatory Care of a medical center or clinic with fee-basis outpatient authority.

12.03 RELEASES

a. The following types of releases may be used for patients leaving VA inpatient care and entering nursing home care:

(1) Regular discharge

(2) OPT discharge

(3) NBC discharge

b. Discharges from nursing home care are reported in one of the following categories:

(1) Regular discharge

(2) OPT discharge

(3) Deaths

(4) NBC

c. A patient transferred from one VA NHCU to another will be shown as a transfer out.

d. A patient who enters a medical center from CNHC or a VA NHCU is considered absent from nursing home care for reporting purposes, except as provided for in paragraph 12.40d.

e. Discharges from the CNHC program will be shown on the daily G&L (Gains and Losses) sheet as non-losses.

12.04 OUTPATIENT CARE

a. Patients who satisfy requirements of VA Regulation 6060(F) may be placed on OPT/NSC status (unless eligibility exists under another appropriate subparagraph of VA Regulation 6060) at the time they are released from a VA medical center for care in a CNH, at any time thereafter prior to discharge from the nursing home, or at the termination of contract care, if professionally indicated, without requiring readmission to a VA medical center.

b. Veterans requiring care for service-connected disabilities and admitted directly to a CNH from their residence may be placed in an outpatient status under VA Regulation 6060 at the time of admission to the nursing home, at any time thereafter prior to discharge from the nursing home, or at the termination of contract care.

12.05 INSTITUTIONAL AWARDS AND NBC STATUS

a. An institutional award being paid to a VA medical center Director may be continued when the patient for whom it is being paid is discharged for admission to either a VA NHCU or to a CNH at VA expense. An appropriate statement will be made in the "Remarks" space of VA Form 10-7132 in such a case and a hospital summary along with VA Form 10-7132 will be forwarded to the Adjudication Division. (See chs. 6 and 8.)

b. Patients for whom institutional awards are received will be placed on NBC status upon discharge from inpatient care. They will remain on NBC status until appointment of a guardian or fiduciary has been made by the VSD (Veterans Services Division).

12.06 NURSING HOME CARE IN STATE HOMES

(See M-1, pt. I, ch. 3.)

12.07 ADMISSION OF WOMEN VETERANS

Women veterans who need nursing home care and satisfy the eligibility requirements for care under VA Regulation 6047 (A), (B), (C), (D) or (E) will not be denied admission to a VA NHCU on the basis of inadequate facilities.

12.08 DEATHS

The provisions of chapter 14 apply to patients who die while receiving authorized care in a VA NHCU or in a CNH (Community Nursing Home) at VA expense. (See par. 12.41 for procedures to follow in CNHs.)

12.09 OTHER ADMINISTRATIVE PROCEDURES

a. Administrative procedures prescribed in DM&S Manual M-1, part I, for hospital patients and domiciliary members are applicable for patients receiving nursing home care unless otherwise specified in this chapter.

b. A patient treated in a NHCU or CNH is not eligible for increased compensation by virtue of receiving 21 days of care in a nursing home.

12.10 REIMBURSEMENT RATES

a. CNHs providing skilled nursing care shall receive a per diem rate commensurate with the care and service provided within the contract agreement, not to exceed the annually prescribed rate. Areas of the country that have been approved for a higher maximum per diem rate receive specific notification of such approval.

b. The per diem rates for ICFs must be commensurately less than those paid for SNF (skilled nursing facility) care, relative to the quality and intensity of services provided. Payment must be at least 10 percent less than the average rate paid by the contracting facility for SNF care at the time of the contract award.

12.11 PRIORITIES FOR NURSING HOME CARE

a. The following priorities (as appropriate) will apply for admission to VA NHCUs and CNHs:

(Priority 1) Veteran patients receiving hospital care in VA facilities who require NHC (nursing home care) for a service-connected or adjunct disability and active duty inpatients who require a procracted period of nursing care and will become veterans upon discharge from active military service.

(Priority 2) Veterans not hospitalized by the VA who require NHC for service-connected or adjunct disabilities.

(Priority 3) Veterans with a service-connected disability who are receiving VA hospital care and require NHC for non-service-connected disabilities.

(Priority 4) Veterans with a service-connected disability not hospitalized by the VA who require NHC for non-service-connected disabilities. (Not appropriate for CNHC)

(Priority 5) Non-service-connected veterans receiving VA hospital care who require NHC.

(Priority 6) Non-service-connected veterans not hospitalized by the VA who require NHC. (Not appropriate for CNHC)

b. For the purpose of applying the priorities in the management of nursing home waiting lists, veterans in VA nursing home programs and VA domiciliaries will be considered as hospitalized.

12.12-12.14 (RESERVED.)

SECTION II. VA NURSING HOME CARE UNITS

12.15 ADMISSIONS

a. Admission to a VA NHCU may be provided under VA Regulation 6047 (A), (B), (C), (D) or (E) when medically determined necessary. Non-service-connected veterans under age 65, not in receipt of pension, and not entitled to medical care under a State Medicaid program, must provide evidence of their inability to afford the cost of care elsewhere.

b. In addition, veterans considered for admission to a VA NHCU must also meet all of the following conditions:

(1) Require nursing home care as defined in paragraph 12.02; and/or

(2) Not require active hospital care;

(3) No longer meet self-care criteria for continued care in a VA domiciliary as specified in VA Regulation 6047 (C) (3) and (D) (3); or

(4) Not require medical care on a day-to-day basis, need frequent clinical monitoring and laboratory studies, require intensive medical care or be terminally ill with a life expectancy of less than 3 months.

12.16 SCREENING COMMITTEE

a. A multidisciplinary Screening Committee will be appointed consisting of the Supervisor, NHCU, a physician responsible for the direct medical care of NHCU patients, a social worker, and other personnel as the facility Director deems appropriate, who will make recommendations for admission. An informal discussion with the professional staff requesting the admission may be desirable in certain cases before arriving at a final decision.

b. The Screening Committee shall meet as often as necessary to avoid undue delay in considering requests for care.

c. Applicants who are currently hospitalized or domiciled at the same medical center where the NHCU is located will not be given preference over applicants from other VA medical centers. The medical district coordinator shall review the source of admission data to insure equal availability of beds for veterans within a reasonable distance of each NHCU. This may include establishment of primary service areas with bed allocations.

12.17 ADMISSION PROCEDURES

a. Referring medical centers, outpatient clinics, domiciliaries or private physicians:

(1) Request for admission to a NHCU will be initiated by the patient's or member's physician and will be supported by sufficient medical findings to show that the veteran meets the requirements of paragraph 12.15. The request shall be supported with VA Forms 10-10 and 10-10m for applicants from the community. Each request will be forwarded to the Chief, Medical Administration Service for processing.

(2) The Chief, Medical Administration Service, will be responsible for review to assure that all necessary requirements have been sufficiently documented.

(3) If the medical center has an NHCU, Medical Administration Service personnel will forward the request to the Screening Committee unless it has been determined that the request should be referred for consideration to a NHCU at another VA medical center.

(4) If the referring medical center does not have an NHCU, or it has been determined that the patient should be admitted to a NHCU at another VA medical center, the request will be processed in the same manner as an interhospital transfer request. The referring facility must include a copy of the completed VA Form 10-10 and most current eligibility document in addition to the medical information prescribed in chapter 11.

b. **Receiving Hospital.** The Chief, Medical Administration Service is responsible for prompt referral of all requests for NHC to the Screening Committee and for prompt action and notification to all concerned after a decision is made. All necessary arrangements will be coordinated with the Chief, Medical Administration Service, at the referring medical center.

12.18 WAITING LIST

a. A waiting list will be maintained by Medical Administration Service for admission to the NHCU. The waiting list will be maintained by priorities and by date of application.

b. Each patient on the waiting list shall be provided with an honest appraisal of the chances for admission. The patient will remain on the waiting list until he or she is admitted, requests removal, or for any other reason he/she would be unable to accept admission.

c. Individuals on the waiting list will be contacted no less than annually to determine if interest still exists for admission to a VA NHCU.

d. Selection of patients from the waiting list will be made according to priorities and earliest date of application.

12.19 RELEASE TO A COMMUNITY NURSING HOME

a. When it is later determined by an objective and realistic evaluation that a non-service-connected veteran in a VA NHCU has alternative resources available that are adequate for defraying the cost of continued nursing home care in the community, arrangements will be made for outplacement from the VA NHCU.

b. When it is in the best interest of the patient and consistent with optimal utilization and management of the NHCU, a patient may be discharged from the NHCU and placed in a contract community nursing home at VA expense in accordance with paragraph 12.32. Non-service-connected veterans or service-connected veterans receiving care for non-service-connected conditions may be discharged to a contract community nursing home from an NHCU only when their entry into the NHCU was preceded by a period of inpatient hospital care at VA expense. Veterans not otherwise entitled to direct CNH placement may not be placed in a CNH at VA expense following a direct admission to the NHCU.

12.20 GAINS AND LOSSES (G&L) SHEET—BED CENSUS

A separate G&L sheet is not required to report gains and losses of nursing home care patients, but this information will be reported on the regular G&L sheet of the medical center under an appropriate heading. The same heading will be used in the bed census report, and separate totals of hospital, domiciliary, and VA NHCU patients will be shown.

12.21 ABSENCES FROM CARE

a. VA Nursing home patients who require admission to the hospital will be placed on Absent Sick-in-Hospital status and reported as such on the G&L sheet. Patients who remain in the hospital for 30 days or less will be assured a bed in the nursing home unit when released from hospitalization. If hospital care is required beyond 30 days, the patient will be discharged from the nursing home and reported on the G&L sheet as Losses From Absent Sick-in-Hospital.

b. The provisions in DM&S Manual M-1, part I, chapter 10 will apply for authorized absences of VA NHCU patients.

12.22 STORAGE OF CLOTHING AND VALUABLES

The provisions of M-1, part VII, chapter 9, are applicable.

12.23 (REVERSED.)

SECTION III. COMMUNITY NURSING HOME CARE

12.24 GENERAL

a. Nursing home care may be provided in public or private community nursing homes at VA expense under the conditions and subject to the limitations prescribed in this section. The VA Community Nursing Home program is designed to assist the veteran and his/her family in making the transition from the hospital to the community. The primary goal of the program is to maintain or restore the veteran to the highest level of health and well-being attainable. It is essential that arrangements for care respond to the veteran's needs at any given point in time and that a flexible long-term plan be initiated prior to placement. For many, placement will represent an interim period of care pending completion of arrangements to return to their own homes, residential care homes, or homes of relatives or friends. Others may need to remain in the nursing home indefinitely. Prior to a patient being placed in a CNH, plans should at least be in the developmental stage for obtaining necessary financial assistance for continuing care following termination of the contract.

b. Consistent with VA Regulation 6050.2, the term VA medical center as used in this chapter also means non-VA hospitals in Alaska and Hawaii.

c. VA Regulation 6051 provides for transferring eligible veterans from VA hospitals to contract nursing homes when the veteran has attained maximum hospital benefit. They will be reported on the Automated Management Information System Inpatient Care Report, VA Form 10-7400-1, as losses to "all other" or to "post-hospital care," item 05 or 06, and as gains to "admissions," item 01 or 02, on VA Form 10-7400-4, Community Nursing Home Care Activity report.

d. Volunteers may be assigned to serve VA patients in a Community Nursing Home when prior coordination has been made with management of the nursing home. Assigned volunteers are subject to the requirements and restrictions on selection and acceptability, and eligible for the services and benefits, applicable to volunteers serving at VA medical centers, according to provisions of DM&S Manual M-2, part XVII. Voluntary Service at the responsible medical facility will select, orient and assign volunteers to an appropriate service upon request. The utilizing service will provide supervision, evaluation and in service training of assigned volunteers. Volunteers assigned by the VA to community nursing homes will wear insignia identifying them as volunteers of the VA medical facility. They will be credited in VA Voluntary Service records only with time devoted to serving VA patients and time required to travel between volunteer assignments.

12.25 RESPONSIBILITIES

a. Medical center Directors are responsible for designating members of a community nursing home inspection team. As a minimum, the team will consist of a professional nurse, social worker, physician, dietician, pharmacist, fire safety officer, supply service contracting officer and a representative from Medical Administration Service. The medical center Director will designate one team member as the coordinator. The function of the team will be to:

(1) Review inspection findings of other agencies.

(2) When considered necessary, conduct as a full team or as a partial team, inspections of community nursing homes.

(3) Recommend approval, disapproval or termination of contracts.

(4) Provide guidance in the management of the Community Nursing Home program.

b. The VA has the right and responsibility to assess nursing homes, in order to be an informed purchaser of care. However, it should be clear that in assessing nursing homes, the VA does not, in any way, regulate these homes, nor does it provide them with any credentials following completion of a successful assessment.

c. The medical center contracting officer is responsible for negotiating and consummating contracts with community nursing homes. On a quarterly basis, each medical district will receive from the Data Processing Center, Austin, Texas, an updated roster of all contract nursing homes in the district. This will serve as a regional resource for inquiries from VA medical centers.

d. Followup of the veteran will normally be the responsibility of the placing facility and will be conducted primarily by Social Work and Nursing Services. Other services are expected to provide consultation to the nursing home in the followup process as needed. A written referral will be made to another VA medical center or clinic when the distance to the nursing home or other circumstances make followup by the authorizing facility impractical. The medical district coordinator in consultation with the Social Work Council will determine facilities having followup responsibilities for specific nursing homes in the district.

e. Social Work Service will maintain a correct, up-to-date list of veterans (serviceconnected and non-serviceconnected) outplaced under contract to community nursing homes. This list will be immediately available in the event of disaster or other incidents. This list will also be available to VA volunteers participating in the nursing home program and to the Chief, Medical Administration Service.

12.26 PROCEDURE FOR INITIATING A CONTRACT

a. Upon receipt of a request from the nursing home to be included in the VA contract nursing home program, the Chief, Supply Service or contracting officer will mail an SF 129, Bidder's Mailing List Application, VA Form 10-1170 and a descriptive cover letter to the applying nursing home.

b. Contracts should be negotiated at rates which reflect the current market value of NHC in the local community. Skilled nursing homes shall receive a per diem rate commensurate with the care and services provided, not to exceed the approved maximum rate. Certain States or areas of the country have been approved for a higher maximum per diem rate and VA medical facilities in those areas are notified of the higher per diem. Normally, Medicaid (Title XIX) rates provide an index to prevailing community rates. Since Medicaid rates are generally not all inclusive, an amount up to the approved maximum rate for the area may be negotiated for an all inclusive contract.

c. The per diem rates for intermediate care facilities must be commensurately less than those paid for skilled care, relative to the quality and intensity of services provided. Payment must be at least 10 percent less than the average rate paid by the contracting facility for skilled care at the time of the contract award.

d. After return receipt of the application, an SF 98 and SF 98a, Notice of Intention To Make Service Contract, will be sent to the Department of Labor.

e. The contracting officer will notify the team coordinator of the nursing home's intent. An evaluation will be planned according to procedures outlined in paragraph 12.30. On initial inspections, the nursing home will be notified of the prospective time and date. The report of the evaluation, with recommendations, will be forwarded by the community nursing home team coordinator to the contracting officer. If appropriate, the contract will be completed by the contracting officer. The contracting officer will distribute copies of the contract to Medical Administration Service and Social Work Service and any other concerned services. Medical Administration Service will update information to be inlcuded in Reports Control Symbol 18-3, Community Nursing Home report.

12.27 CONTRACT OBJECTIVES

a. Contracts will be sought with skilled and intermediate care nursing homes for the provision of care which meets VA standards. Every effort will be made to secure contracts to include within the per diem rate, the cost of a room, meals, nursing care, routine medical care, drugs, laboratory, X-ray, and other routine services. If this is not possible, the contract should specify those services and supplies which are not inlcuded in the per diem rate.

b. Contracts negotiated with exceptions will reflect a reduced per diem rate, calculated by decreasing the per diem rate by the estimated daily cost of the excepted items.

c. Items not included in the contract may be provided to veterans eligible for outpatient treatment under VA Regulation 6060 and defined in chapter 17 or 18. When appropriate, additional care on fee basis must be authorized in advance according to paragraph 12.35.

12.28 STANDARDS FOR SKILLED NURSING FACILITIES

VA standards for SNFs (skilled nursing facilities) will henceforth be the same as those used for the certification of nursing facilities for the Medicare or Medicaid programs except that, for the fire safety criteria, the facility shall meet the requirements of the latest editon of the Life Safety Code (NFPA 101).

12.29 STANDARDS FOR INTERMEDIATE CARE FACILITIES

Minimal VA stndards for ICFs are the same as the Federal Medicaid Standards contained in the 42 Code of Federal Regulations, except that, for fire safety criteria the facility shall meet the requirements of the latest edition of the Life Safety Code (NFPA 101). The following additional VA standards will also apply for nursing services:

a. The Nursing Service is under the direct supervision of a full-time (40 hours) professional nurse, currently licensed to practice in the State.

b. There is at least one registered professional nurse or licensed practical nurse or vocational nurse (a graduate of a State-approved school of practical nursing) on duty and in charge of nursing activities during each tour of duty.

c. Provision is made for appropriately trained personnel to relieve during vacation, sick leave, and other periods of emergency to assure 24-hour coverage.

12.30 EVALUATION OF NURSING HOMES

Nursing homes will be evaluated prior to consummation of a contract with the VA. Accreditation as a Long Term Care facility by the JCAH (Joint Commision on the Accreditation of Hospitals) may be considered evidence of compliance with VA standards. If the medical center Director chooses to accept this method of evaluation, an onsite visit to the nursing home must be made by the social worker and nurse only, according to instructions outlined in paragraph 12.30a(3) below. If the home is not JCAH accredited or if the medical center Director chooses not to accept this method of evaluation, the home must be evaluated by one of the methods outlined below:

a. Certified Facilities (Skilled)

(1) If the nursing home has been certified under Title XVIII (Medicare) or XIX (Medicaid), it will have been inspected by the State agency according to the Federal standards. The community nursing home coordinator will obtain from the State agency, the District Social Security Administration Office, or the Regional Office of the Department of Health and Human Services, a copy of the most recent Form SSA 2567, Statement of Deficiencies and Plan of Correction. This document will note any deviation from standards, the nursing home's plan for correction, and any waivers. The Community Nursing Home inspection team members will review their appropriate sections of Form SSA 2567.

(2) If a review of Form SSA 2567 raises questions as to the suitability of the home for the use of VA beneficiaries, appropriate members of the VA team, or the entire team, if indicated, will visit the home to resolve the questions, applying the cited 42 CFR standards and documenting the findings. VA team members are encouraged to discuss any particular areas of concern noted on Form SSA 2567, with the appropriate individuals at the agency which conducted the survey.

(3) If the review of the Form SSA 2567 is satisfactory, no full team inspection is required. A visit will be made to the home by the team social worker and nurse only. The purpose of this visit will be to describe and evaluate:

(a) The quality and level of care provided;

(b) The quality of life in the facility;

(c) Facility programs to meet the needs of veterans;

(d) Special characteristics of the facilities.

The description and evaluation will be documented and will be used to determine how this facility might best be used to serve the needs of the target veteran population. For fire safety requirements, the Form SSA 2567 will be compared, by the Safety Officer, with the latest edition of the Life Safety Code to determine if a visit is required.

(4) Based on the above evaluation processes, recommendations will be made by the community nursing home team coordinator to the contracting officer for disposition of the application. If problem areas are noted, the nursing home must be advised of the deficiencies in writing by the contracting officer and given a reasonable amount of time to take corrective action. A contract may be issued while corrective action is being pursued only if it is determined that the health and safety of the veteran will not be compromised in the meantime.

(5) The same procedures outlined for the certified SNF facilities (above) will apply to certified ICF's except that the VA community nursing home team must determine that the home also meets the additional standards for nursing services outlined in paragraph 12.29 above. This can be determined by a review of the application for contract, VA Form 10-1170, and by the nurse/social work quality and program evaluation visit.

(6) The evaluation process will be completed and documented at least annually. The team coordinator will recommend to the contracting officer continuation or termination of the contract each year based on the evaluation process. If a contract is canceled and renegotiated during the year for the purpose of establishing a new per diem rate, it is not necessary to conduct another evaluation so long as the evaluation has been conducted within the required yearly time limit.

NOTE: In order to monitor the quality of inspections conducted by other agencies, VA medical centers may conduct onsite evaluations on a routine sampling basis as determined by the team coordinator. It is the clear intention of the VA to minimize unnecessary and redundant Federal inspections of nursing facilities through the processes outlined in this chapter. However, it is emphazied that the VA medical center retains and right and carries the responsibility to conduct an onsite VA inspection by a full or a partial team at any time it is considered necessary to insure that quality care is provided to veterans in a safe environment.

b. Noncertified Facilities (Skilled and Intermediate)

(1) Nursing homes not certified under Title XVIII (Medicare) or Title XIX (Medicaid) will be evaluated on site by the following community nursing home team members: social worker, nurse, dietician, and fire safety officer, using the standards outlined in 42 CFR. The team physician and clinical pharmacist and any other discipline will be included in the inspection as appropriate. The social worker and nurse members of the team will, in addition to applying standards of 42 CFR, describe and evaluate the facility according to the principles outlined in paragraph 12.30a(3) of this chapter.

(2) Following completion of the evaluation, findings will be documented and a recommendation will be made by the community nursing home team coordinator to the contracting officer for disposition of the application.

c. VA medical centers will, on request, make information concerning contract nursing homes available to Federal, State, and local agencies charged with the responsibility of licensing, regulating or inspecting these homes. In addition, VA medical centers will, on their own initiative, make available to these agencies, information about facilities which are found to have serious deficiencies which may threaten the health or safety of residents.

12.31 ELIGIBILITY

a. A veteran who requires nursing home care for a service-connected disability may be placed in a contract community nursing home from a VA facility or directly from the community. The determination of need for nursing home care may be made by a VA or private physician, but in all cases, the decision to admit a service-connected veteran directly to a community nursing home must be made by a VA physician.

b. Veterans who have been hospitalized primarily for treatment of their service-connected disability and require nursing home care for any disability are entitled to nursing home care as long as such care is necessary. Continued annual authorizations may be approved until nursing home care is no longer needed.

c. Patients will not be admitted to a VA medical facility for the sole purpose of transferring them to a community nursing home. However, beneficiaries hospitalized at VA expense in a non-VA hospital may be transferred to a nearby VA facility for this purpose (not necessary in Alaska or Hawaii).

d. Veterans are not entitled to community nursing home care for a non-service-connected disability unless they were hospitalized in a VA facility under VA Regulation 6047 and received other than an irregular discharge. In addition, they must need nursing home care for convalescence, rehabilitation or continued care for a protracted period of time. Normally, this will be interpreted to mean a minimum of 3 months.

e. The requirements of paragraph 12.37 must be met if care is extended beyond a period of 6 months for a veteran whose hospitalization was primarily for treatment of a non-service-connected disability. Periods of absence from the nursing home for which no VA payment is made will be counted as part of the 6-month period.

f. Short-term rehospitalization in a VA facility (15 days or less) for diagnostic workup or brief intercurrent illness will not be considered justification for beginning a new 6 month period of eligibility for community nursing home care. (See par. 12.38c.)

g. Patients held in VA facilities under commitment will not be placed in this program unless their behavior and prognosis justify termination of the commitment. In those States where termination of a commitment is not accomplished automatically when the patient is released, the necessary action will be completed prior to or at the time of admission to the community nursing home.

h. Active duty military patients may be eligible for community nursing home care. (See par. 12.33.)

12.32 SELECTION AND MOVEMENT OF PATIENTS

a. Selection of patients for placement in community nursing homes will normally be made at ward level by the patient's physician, nurse and social worker, subject to approval by the Chief of Staff of the facility.

b. Patients will be given the opportunity to choose a nursing home from facilities approved by and available to the VA. Listings of local nursing homes will be maintained by each VA facility. Information on other nursing home contracts is available at the appropriate medical district office. Admission to the nursing home will be accomplished promptly following completion of hospitalization.

c. VA Form 10-1204, Referral for Community Nursing Home Care, will be prepared by the ward clerk or secretary. The responsibility for providing the necessary information rests with the physician, nurse, social worker, dietician or other source. The form will be filled out as completely as possible. If additional space is needed for any item, the "Remarks" space may be used or additional information may be furnished separately and attached to the form. When appropriate, forms required by local public assistance agencies will also be completed.

d. If the proposed placement is approved by the Chief of Staff, the Chief, Medical Administration Service, or designee, will contact a nursing home official to ascertain availability of a bed unless the social worker has already done so and it is so indicated on VA Form 10-1204. The medical facility will be responsible for complying with any requirements of local governments or regulatory bodies prior to movement of the patient to the nursing home.

e. The original VA Form 10-1204 will be forwarded to the nursing home so that it is available when the patient arrives. A copy will be filed in the veteran's administrative records folder at the medical facility. An additional copy will be reproduced and forwarded to the facility which is to conduct the followup, if other than the authorizing facility.

f. VA Form 572, Request for Change of Address, will be completed if necessary by Medical Administration personnel prior to departure of the veteran from the medical center. If there are any unresolved questions about other VA benefits, the veteran will be referred to the Veterans Benefits Counselor for interview.

g. Early planning will be initiated to assure that needed dental care or prosthetic or similar appliances are furnished prior to discharge from the VA facility.

h. A nursing home retains the right to refuse to accept any patient when it is anticipated that the cost of the care and services required would exceed the scope of the contract.

12.33 ACTIVE DUTY MILITARY

a. An active duty military patient in a VA medical center may be transferred to a contract community nursing home if he/she has received maximum hospital benefits. The appropriate service branch shall be notified of the transfer.

b. Active duty military patients may be transferred directly from a military hospital to a community nursing home under VA contract. The service department must assure the VA that the subsequent discharge from the service will be other than a bar to VA benefits.

(1) The Director of the VA medical center closest to the home address of the patient, or the address provided by the service hospital, is responsible for all VA actions involved in the transfer. This includes but is not limited to liaison with ASMRO (Armed Services Medical Regulating Office) liaison with community nursing homes, authorization and payment of nursing care, followup visits to evaluate patient care, and reimbursement requests to the appropriate service department.

(2) A request for transfer will be initiated by the service hospital through ASMRO to the VA medical center concerned. Requests from ASMRO for bed reservations in a community nursing home will be given priority processing. Teletype responses to ASMRO will contain the name and address of the community nursing home, date of bed reservation and the name and telephone number of the VA employee to be contacted in the event the staff at the service hospital wishes to discuss the case prior to the patient's transfer. Once the service hospital has been notified by ASMRO that a bed is available, and transportation arrangements have been made, the VA medical center will be notified of the expected time, mode of transportation and place of arrival. Transportation from place of arrival to the community nursing home will be provided by the VA unless otherwise specified by the service hospital. Such transportation will be provided on a reimbursable basis.

(3) When making a bed reservation, the VA medical center will attempt to make an "on or about" reservation to provided latitude in the arrival date when the patient is transported via MAC (Military Airlift Command). Community nursing homes shall be kept advised by the VA of any change in the anticipated arrival of the patient. Admission to the VA medical center will be approved when necessary in order to provide for a smooth transfer to the community nursing home.

(4) VA Form 10-1204, Referral for Community Nursing Home Care, or an equivalent form from the department of Defense and a summary of the patient's condition should accompany the patient.

c. At the time of discharge from active duty an eligibility determination will be made. Based upon the eligibility determination, nursing home care will be provided in accordance with paragraph 12.31 of this chapter.

d. Reimbursement for care at VA expense will be requested from the appropriate department in accordance with procedures in M-1, part I, chapter 15, while the patient remains on active duty status.

12.34 PROCEDURES IN ALASKA AND HAWAII

The procedures in paragraph 12.32 a through g will be used in Alaska and Hawaii to the extent feasible and appropriate. When applicable, the procedures prescribed for non-VA hospitalization in chapter 21 will be followed.

12.35 AUTHORIZATIONS

a. VA Form 10-7078, Authorization and Invoice for Medical and Hospital Services, will be used by facilities to issue authorizations for nursing home care. The authorization validity period will be from the initial effective date to "disposition." (For those veterans whose hospitalization was primarily for treatment of non-service-connected disabilities, and for those admitted directly for nursing home care for service-connected disabilities, add "but not later than (insert date—not to exceed 6 months).") Funds will be obligated on VA Form 4-1358, Estimated Miscellaneous Obligation or Change in Obligation, as prescribed in MP-4, part V.

b. VA Form 10-7078 will be further annotated to authorize additional payment by the VA for items of medical care, emergency dental care, drugs, laboratory, X-ray, or other necessary services not included within the per diem rate. The maximum average amount payable per day for such services will be stated, and the cost of any services to be furnished by the VA will not exceed the amount by which per diem rate was decreased as provided for in paragraph 12.27b. The total cost of care may not exceed the maximum allowable per diem rate, as published in current directives, except as noted in paragraph 12.27c.

12.36 PLANNING AND FOLLOWUP

a. Prior to placement in a community nursing home, consideration will be given to postcontract planning. If there clearly is no viable postcontract plan and the veteran will most likely be returned to the VA medical center, the veteran should not be placed in a community nursing home. Social Work Service will actively assist the veteran and/or family in planning to assume responsibility for his/her future needs following nursing home care at VA expense. Benefits and potential benefits, VA and other, will be fully explored and explained to the veteran and/or the family. Appropriate assistance is available from the Veterans Benefits Counselor.

b. Each patient admitted to a community nursing home will be visited no less frequently than every 30 days by the community nursing home nurse or social worker. Observations will be made as to the quality of professional care and need for continuation of nursing home care. Guidance may be provided to CNH staff in the provision of care for veterans under contract. Consideration may also be given to utilization of other community nursing home team members for followup services.

c. The nurse assigned to the Community Nursing Home Program will make followup visits to insure that adequate and safe care is being provided.

d. The social worker assigned to the Community Nursing Home Program will make followup visits to:

(1) Assist the patient and/or family with the social and emotional aspects of the transition to long-term care.

(2) Assist the patient and/or family in planning for continued care in nursing home if indicated.

e. If plans for outplacement at non-VA expense cannot be completed prior to the expiration of the VA authorization, the social worker will continue to offer assistance in planning. If there are valid reasons for continued care at VA expense and the veteran meets the requirements in paragraph 12.37, consideration will be given to extending the period of VA authorized care at the community nursing home.

f. If outplacement at non-VA expense for a veteran whose hospitalization was primarily for treatment of non-service-connected disabilities is feasible, but the veteran and/or family decline to cooperate, the VA authorization will be terminated. Written notification of the pending termination will be made to the veteran and/or family, the community nursing home and any other interested parties. Termination will be effective 30 days following written notification or at the expiration of the current authorization, whichever comes first.

g. Placement from a VA medical center to a contract nursing home at VA expense may be denied to a veteran seeking care for a non-service-connected condition if it is objectively and realistically determined that an alternative to VA contract care is feasible but the veteran or the veteran's family declines to utilize the alternative. However, if an alternative arrangement is made to VA care, such as public assistance, and the veteran declines to use this potential benefit, the VA may deny placement at VA expense.

h. Patients remaining in the community nursing home for an extended period of time (more than 1 year) will be given a comprehensive physical examination no less often than once a year to determine the need for continued nursing home care. Such examinations will be done, to the extent practicable, on a staff basis at the VA medical facility nearest the community nursing home. If this is not feasible, the examination will be done at the nursing home on a fee basis or by a VA physician. The report of examination will be reviewed by the community nursing home team to determine the need for continued care. A copy of the report of examination will be furnished to the community nursing home for inclusion in the patient's record.

12.37 EXTENSIONS BEYOND 6 MONTHS

a. Extensions beyond 6 months for veterans whose hospitalization was primarily for treatment of non-service-connected disabilities or for veterans admitted directly to the CNH because they required nursing home care for service-connected disabilities, will be held to a minimum and must meet all of the following conditions:

(1) Both medical and economic need exist.

(2) Circumstances of a most unusual nature have prevented discharge from the nursing home or assumption of financial responsibility by the family or community within the 6-month period. (An impasse in planning for community care will not be considered an unusual circumstance for this purpose.)

(3) There is evidence of adequate planning for community care with reasonable expectation that VA authorization for nursing home care cona be discontinued on or before the expiration of the extended period.

(4) Extension is approved by the medical center Director.

b. Extensions must be for a specific period of time, not to exceed 6 months.

c. Cases which meet the requirements of subparagraph a (1), (2) and (3) above will be fully developed and documented, inlcuding recommendations of the physician, nurse and social worker. Cases will be forwarded to the medical center Director at least 30 days prior to expiration of the current authorization.

12.38 READMISSION TO A MEDICAL CENTER

a. Patients requiring emergency rehospitalization will be admitted to an appropriate VA facility immediately, unless this is not feasible because of distance or urgency. If rehospitalization is required or the veteran begins to require more than occasional visits by physicians or more than minimal laboratory, X-ray and other services, readmission to a VA facility will be accomplished promptly. The priorities established in VA Regulation 6049 (A) (3) and (B) (2) do not apply in these circumstances, since the readmission only constitutes a change in benefit for a veteran already receiving VA care.

b. Payment may be made by the VA under the appropriate subsection of VA Regulation 6050.2 for hospitalization in a medical emergency in a non-Federal hospital if all of the following conditions are met:

(1) VA authorization in each case had been obtained. (This condition will be considered to be met if the request for authorization was received by the VA within 72 hours after the date and hour of admission.)

(2) Prompt readmission to a VA or other Federal hospital with which the Administrator contracts is not feasible.

(3) Authorization is limited to the period of care required to meet the emergent need until the veteran can be safely moved to a VA facility.

c. Patients who remain in hospital or domiciliary care beyond 15 days, including the date of admission, will be reported on VA Form 10-7400-4 or VA Form 10-7400-2 in the appropriate column under "Losses of Patients Absent Sick in

Hospital." (The patient's return to contract nursing home care will be under the provisions of a new contract placement.) A patient remaining in the hospital or domiciliary for 15 days or less, and who returns to a contract nursing home, will resume care under the previous period of 6-month eligibility.

12.39 ADDITIONAL CARE

a. The authorizing facility is responsible for the furnishing of care professionally recommended and for which the veteran is eligible under the provisions of paragraph 12.01. For care not provided for by the nursing home in accordance with the terms of the contract, treatment will be furnished on a staff basis, to the extent practicable, at the authorizing medical center or, by prior arrangements, at another VA medical center.

b. When staff care is impracticable, fee care will be authorized by the placing medical center. Medical centers without fee-basis jurisdiction will authorize such care by issuing VA Form 10-7078, Authorization and Invoice for Medical and Hospital Services. Fee-basis clinics of jurisdiction will authorize such care in accordance wth chapter 18.

12.40 BILLING AND REPORTING PROCEDURES

a. Nursing homes will be requested to submit invoices to the authorizing facility on their own letterhead at the completion of each month's service. A completed VA Form 10-1204b, Report of Nursing Home Care, for each veteran, will accompany the bill. The facility will furnish a reproduction of the report to the VA facility conducting followup of the case.

b. Billings, received from the nursing home, veteran's physician, or other third parties for supplemental services or supplies authorized under paragraph 12.35b may be approved and processed for payment if otherwise in order. Supplemental authorizations will not be issued. The maximum amount allowed for such services may be computed prospectively, based on a period not to exceed 30 days. Care will be exercised, however, to insure that the maximum will not have been exceeded when nursing home care is terminated. Cases will be reviewed periodically so that those which will require more than an average of the allowable maximum may be promptly readmitted to a VA facility.

c. Payment may be made for either the first or last day of nursing home care, but not for both. If the patient is admitted and discharged on the same day, payment will be made for 1 day. (Exception: Payment may be made for both the first and last day of care if the patient is to remain in the same home and financial responsibility for continued maintenance of the patient at the nursing home is to be assumed by another person or agency following termination of the VA authorization.)

d. If a contract patient is placed on authorized absence for therapeutic purposes or hospitalized, the VA may reimburse the CNH at the authorized per diem rate for reserving the bed for such period of absence not to exceed 48 hours. Reimbursement for similar absences in excess of 48 hours will not be made except when specifically authorized in advance and approved by the Chief, Medical Administration Service. Authorization will not be given and payment will not be approved for reservation of CNH beds beyond 5 days.

12.41 DEATHS

a. When a VA patient under contract in a community nursing home dies, the utmost assistance will be afforded relatives in arranging a dignified funeral and burial. The provisions of chapter 14 will apply to patients in community nursing homes.

b. The nursing home will immediately notify the VA facility which authorized the admission, assemble, inventory and safeguard the deceased patient's personal effects. The funds, deposits, and effects left by VA patients at the nursing home shall be delivered by the nursing home to the person or persons entitled thereto under the laws currently governing the nursing home for making disposition of funds and effects left by patients, unless the veteran died without leaving a will, heirs, or next of kin capable of inheriting. When disposition has been made, the itemized inventory with a notation of the disposition will be immediately forwarded to the VA facility authorizing admission. Should a deceased patient leave no will, heirs, or next of kin, the personal property and funds wherever located vests in and becomes the property of the United States in trust. In these cases, the nursing home will forward an inventory of any such property and funds in its possession to the VA facility and will hold them (except articles of clothing necessary for proper burial) under safeguard until instructions are received from the VA.

12.42 NOTIFICATION TO ADJUDICATION DIVISION

a. VA Form 10-7132, Status Change, will be prepared by the VA facility which authorized the admission and furnished to the Adjudication Division in compliance with item 1, part III, of VA Form 10-7131, Exchange of Beneficiary Information and Request for Administrative and Adjudicative Action, to report the discharge of a veteran to a community nursing home. VA Form 10-7131 will be used to notify adjudication of the direct admission of service-connected veterans to community nursing homes. VA Form 10-7131 and VA Form 10-7132 will include the name and address of the nursing home.

b. The VA facility will furnish an additional completed VA Form 10-7132 to the Adjudication Division to report disposition from the nursing home of each patient for whom a copy of VA Form 10-7131 or 10-7132 was submitted as prescribed in subparagraph a above. Periods of absence from the nursing home for which no VA payment is made will be reported as prescribed in chapter 6. The Adjudication Division will request any other needed information by submitting VA Form 10-7131 to the authorizing medical center.

Question 9A. What is the average length of stay in a contract nursing home for (i) a service-connected veteran and (ii) a nonservice-connected veteran?

Answer 9A. In Fiscal Year 1981 the length of stay in a contract nursing home was 234 days for a service-connected veteran and 112 days for a nonservice-connected veteran. (The length of stay for nonservice-connected veterans is low since the VA is authorized to provide this care for a period of time not to exceed six months.)

Question 9B. What is the average length of stay in a VA nursing home for (i) a service-connected veteran and (ii) a nonservice-connected veteran?

Answer 9B. In Fiscal Year 1981, the average length of stay in a VA nursing home was 448 days for a service-connected veteran and 504 days for a nonservice-connected veteran.

Question 10A. On the average, what percentage of a VA nursing home care unit is devoted to care of patients in each of the levels ot care I through IV and what percentage of a VA contract community nursing home is devoted to care of patients in each of these levels?

Answer 10A. The average distribution of levels of care in VA nursing homes for the first half of FY 1982, ending on March 31, 1982, was: Level I - 31.0 percent; Level II - 37.5 percent; Level III - 24.8 percent; and Level IV - 6.7 percent.

In the Community Nursing Home Program, skilled facilities (SNFs) provide care which is roughly equivalent to Levels I and II, while intermediate care facilities (ICFs) provide care equivalent to Levels III and IV. As of March 31, 1982, approximately 71 percent of veterans in community nursing homes were placed at the skilled level and 29 percent at the intermediate level.

Question 10B. Please describe the extent to which VA nursing homes and community nursing homes are generally capable of providing each of these levels.

Answer 10B. VA nursing homes have the capability of providing care to 70 percent of patients in Levels I and II and 30 percent of patients in Levels III and IV. Contract homes in the community have the option of either accepting or denying admission of a veteran, depending on their capability to provide the needed services at the authorized per diem rate. We have experienced little difficulty in locating the appropriate level of community nursing home care for veterans. However, there is more difficulty in placing those veterans who require total care.

Question 11. What types of difficulties does the VA generally encounter in attempting to place veterans in community nursing homes on a contract basis?

Answer 11. With the exception of occasional, temporary problems in obtaining community nursing home beds which meet standards at an acceptable per diem rate, the VA has experienced no system-wide difficulties with this program.

Question 12. Would an increase in per diem rates to community nursing homes result in greater acceptance of contract VA patients by community nursing homes able to provide the necessary care?

Answer 12. No. The VA already has the authority to set per diem rates up to 45 percent of the per diem rate of a VA general hospital (50 percent in exceptional cases). This is sufficient for the VA to purchase care in all but the most unusual circumstances.

Question 13A. The Administrator's March 17, 1982, letter regarding construction revalidation noted that VA nursing home construction costs average $131 per square foot, as compared to an average of $58.65 per square foot in the private sector.

What accounts for this difference in costs?

Answer 13A. The difference between private sector and VA nursing home costs is attributable to the following:

1. The "Federal presence" carries with it a multitude of contract requirements which increase cost. The most noticeable of these requirements are the various social policy programs imposed by law on Federal construction contracts.

2. Mechanical systems in Federal facilities are required to meet energy conservation standards mandated by a Presidential Executive Order; hence they are more costly than systems usually installed in proprietary, private sector facilities.

3. The types and qualities of materials and equipment in VA construction are selected with consideration of both initial and life cycle costs. It is believed that the private sector is encouraged by tax laws to give primary consideration to first cost.

4. Budget estimates for VA construction projects represent the estimated total project cost at a future time of construction, whereas the costs cited for private facilities usually are base construction contract prices at an earlier time and do not include technical

services fees, contingency allowances, or projected inflation. Moreover, it is not clear whether the published costs of private nursing homes include or exclude the costs of equipment and other items which may be subject to special tax credits and accelerated depreciation allowances if excluded from the building contract.

5. VA nursing homes are built upon the sites of existing VA Medical Centers and must be connected to existing utilities systems and adapted to site-specific conditions. Private sector nursing homes usually are built on sites selected with a view to minimizing the costs of such site-mandated construction requirements.

6. VA nursing homes are equipped with complete systems of automatic sprinkler protection, and are barrier-free throughout. Private sector facilities generally do not conform to the same standards.

Question 13B(i). Please describe steps that the VA is taking to reduce its nursing home construction costs and provide a time-table for these steps.

Answer 13B(i). In November 1981, a Nursing Home Construction Cost Reduction Task Force was formed to propose, evaluate and implement ways to reduce the construction costs of VA nursing homes. The Task Force, made up of representatives from DM&S and O/C, has proposed over 60 items to reduce construction costs. Although some of these proposals, after evaluation, were rejected, the remaining proposals have, or will be, incorporated into the nursing home designs. Some of the proposals were of a nature that they could be incorporated immediately into the working drawings of approved NHCU projects while most of the others could not be incorporated immediately because this would cause undue delay in completion of design work. These remaining proposals will be incorporated into the design of all future NHCU's starting with the FY 1983 projects. In total, the acceptable proposals represent approximately a $2,000,000 cost reduction. The proposals, thus far, have centered around reductions in space allocated to the various NHCU programs. Examples are reductions in the size of dining and recreation space, reductions in size of offices and modularization and reduction in size of the patient rooms.

Question 13B(ii). What would be the impact, if any, of such actions on providing health care?

Answer 13B(ii). None of the actions, thus far, are forseen as having any adverse impact on the provision of quality health care. All proposals were evaluated by the applicable DM&S program official and any proposal that showed the potential of having an adverse effect on patient care was rejected.

Question 13C. Would the cost-cutting steps you plan result in any change in the levels of care that VA nursing home care units can provide?

Answer 13C. The cost-cutting steps, thus far, will not result in any change in the levels of care that VA NHCU's can provide. Any proposal that displayed this potentially deleterious effect was immediately rejected by DM&S.

Question 14A. I have been very impressed with the Hospital-Based Home Care Program both for its success in freeing up costly hospital beds and for allowing patients to receive the necessary medical attention while remaining in a home environment, at an average per patient day cost of $15.73. To me this program makes good economic as well as good health-care sense.

What plans are there at present to expand this program?

Answer 14A. The VA presently operates 30 HBHC programs nation wide and maintains an average daily census of 1500 patients. Medical and support services are provided in the home by teams of health care professionals who make over 145,000 home visits per year. Since the agency request for appropriations for FY 1983 was formulated under budget constraints, plans for funding the program will be at the current level. Proposals for funding the program have been received from over 50 hospitals. DM&S will explore ways to expand this program throughout the system during the next couple of years. There is concern, also, about making HBHC available to the rural areas. There is a pilot rural HBHC program at Hot Springs, Arkansas which shows promise.

Question 14B. At those facilities where the program is in operation, to what extent is it available to all those who could benefit from it?

Answer 14B. Prudent management requires that each program achieve and maintain the established average daily census for the 9.25 FTEE team members to be effectively used. It is true that at some programs an increased number of patients could be placed in the program but without increased resources and staff, patient care may be compromised.

Question 14C. Please describe the situations in which Hospital Based Home Care is an effective and desirable treatment modality and indicate the extent to which you believe it would be advisable to expand the program.

Answer 14C. There is some data which indicates that there are patients in all of our hospitals whose continued stay could be avoided by placement in the home. Studies of the program indicate that the leading diagnoses of HBHC patients are heart disease, cancer, stroke, chronic obstructive pulmonary disease and diabetes. The program is being tailored to focus upon a few of these diseases so as to be of greater usefulness to the inpatient care system. From the early stages of the program no attempt was made to select specific diseases as it was thought that all patients who met the eligibility requirements could be admitted. However, by focusing upon a specific disease the HBHC team can develop and maintain closer relationships to the clinical activities of the inpatient unit and the chief of an inpatient service can expand the patient population served through this modality of care. Several of our HBHC teams are being trained by the senior clinician of a specific disease so that the treatment philosophy of that clinician is continued in the home. This project has been enthusiastically received by the involved senior clinicians and by the HBHC teams.

With funds secured from the Administration on Aging, DM&S is studying the types of patients best suited for HBHC, which will enable us to intensify the medical participation of the hospital staff.

Question 15A. What was the average daily census for Fiscal Year 1981 for the Residential Care Program and what do you estimate it to be for Fiscal Year 1982?

Answer 15A. The average daily census for Fiscal Year 1981 for the Residential Care Home Program was 12,700. The estimated census for Fiscal Year 1982 is 12,850.

Question 15B. What is the cost to the VA of administration of the Residential Care Home Program?

Answer 15B. In Fiscal Year 1981, the estimated administrative cost of the Residential Care Home Program Was $4.5 million.

Question 16A. Clearly, many non-medical factors - such as one's social and living environment - are important in the maintenance or recovery of an elderly person's health.

What do you see as the VA's role in responding to such health-related but not strictly medical needs?

Answer 16A. Comprehensive medical care provided in the VA Domiciliary Program is attentive to not only the veteran's specific medical/psychiatric needs, but includes attention to social, vocational, and economic parameters. Each patient's treatment plan includes attention to all of these areas. For the domiciliary patient who is to be helped to return to a community level of adjustment all relevant problem areas must be addressed if the veteran is to make an adequate adjustment.

For aging veterans leaving a VA facility who need continuing non-medical but health related support, VA staff make every effort to refer them to local community based programs such as multipurpose senior centers where a variety of programs focus on providing an improved quality of life.

Question 16B. On page 13 of your statement, you state, "A comprehensive reassessment of the domiciliary program has been completed and we have a new approach to what its mission ought to be." You also suggest that domiciliary admissions will be limited to veterans "requiring access to continuing care or rehabilitation."

Please specify the changes you plan to make in the regulations and other policy directions relating to eligibility for domiciliary care.

Answer 16B. The VA has not yet determined the specific changes that will be required.

Question 17A. What mechanisms do you have to ensure that information regarding advances made and experience gained in geriatrics, particularly, through the various GRECCs, is shared with other health-care providers throughout the VA system and with non-VA providers?

Answer 17A. Education represents a major and significant goal in the GRECC mission. The GRECCs are expected to develop information that will improve the quality of care to elderly veterans and to share this information with other VA and non-VA health care providers. There are several mechanisms by which this information is disseminated: 1) a quarterly GRECC newsletter that is distributed throughout the VA system; 2) on-site training in geriatrics for staff, physician fellows, and students in allied health professions with diffusion of information as trainees return to or move into other VA and non-VA health care facilities; 3) local, regional and national lectures, workshops and conferences, produced by the GRECCs in conjunction with Regional Medical Education Centers, affiliated academic programs, and various geriatric consortia; and 4) the publication of research in professional journals and its occasional citation in newsletters and in the public media.

Question 17B(i). Please describe what those mechanisms have accomplished.

Answer 17B(i). During FY 1981 the professional and scientific staff of the GRECCs collectively published 378 books, chapters, journal articles and abstracts. During this same period they delivered or sponsored 609 lectures, and produced or co-produced 26 conferences. There have been 19 graduates of GRECC affiliated geriatric fellowship programs, 13 of these are now working (at least part-time) in geriatrics within the VA system. Three GRECC newsletters have been published since December 1981 with 5,000 copies printed of each edition; approximately 27 copies of the newsletter are sent to every medical center in the VA hospital system. Currently, through a "cascade" model, the Wadsworth and Sepulveda GRECCs are working with the Southwest RMEC to develop geriatric training programs for every VAMC within that VA medical region. Subsequent to a recent award from the Office of Academic Affairs, the GRECCs are currently developing proposals (that will be subject to merit review) for education programs in geriatrics/gerontology.

Question 17B(ii). To the extent that those changes restrict admission to VA domiciliary facilities, where do you foresee that applicants who would qualify under the existing criteria, but not under the new criteria will be placed?

Answer 17B(ii). Veterans who would not be eligible for admission would be those with "no place to live" or who were seeking room and board or housing. When these veterans apply for domiciliary care or his/her application for care is reviewed, he/she will be counseled about various alternatives. These could include residential home care if he/she were a VAMC inpatient or had outpatient status, State Veterans Home domiciliaries, congregate housing programs, board and care settings, independent living facilities, or other cooperative living programs. At such time as these veterans require medical care, they will be able to apply to a local VAMC for medical care.

Question 18A. What channels and opportunities for scientific communication between GRECCs are available?

Answer 18A. GRECC investigators are able to communicate through multiple channels. These include: 1) attendance at national scientific meetings, such as the annual meeting of the Gerontological Society of America; 2) presentation of their research at other GRECCs in colloquium; 3) participation in cooperative research projects; 4) collaboration on symposia and other presentations for national scientific conferences; 5) co-contributing to books and conferences; and 6) through scientific journals and publications. Currently, a computerized, interactive information system is being developed for the GRECCs. This system should significantly enhance the GRECCs' ability for communication and information exchange.

Question 18B. Have any such opportunities been curtailed because of lack of travel funds?

Answer 18B. No such opportunities have been curtailed due to insufficient funds; however, as VA and non-VA funds for research become increasingly scarce, the resources for supporting meetings for scientific information exchange will become proportionately less.

Question 19A. On page 7 of your statement, you state "we must be granted more flexibility in management of these (GRECC) centers." Could you expand on this for the record please, indicating in precisely what areas more flexibility is needed, what you believe this would accomplish, and whether or not any change in law would be required in order to provide this flexibility.

Answer 19A. We are not prepared to submit a more specific statement at this time.

Question 19B(i). In what ways are GRECCs "less effective in affecting the provision of care" than they should be?

Answer 19B(i). At this time in the evolution and development of the GRECCs, there is more evidence of research and education activity and accomplishments than improvements in clinical services. However, five GRECCs have developed Geriatric Evaluation Units for intensive diagnosis and therapy, and GRECCs also provide consultation and conduct geriatric outpatient clinics. There is expectation that the GRECCs can make significant contributions toward the development of improved models of clinical services for eligible older veterans throughout DM&S and this objective will be emphazied more in the future.

Question 19B(ii). What is needed to make the GRECCs fully effective in this regard?

Answer 19B(ii). The effectiveness of the GRECC program will be related to the the level of resources provided for the identification of advances in scientific knowledge, the dissemination of that knowledge, and the application of such advances through all VA health care facilities.

Question 20A. Dr. Raskind, the Director of the Seattle/American Lake GRECC, discussed in his statement a cooperative study among GRECCs to address various aspects of dementia of the Alzheimer's type. Please describe this study and the cooperative aspects of it further.

Answer 20A. Four GRECCs (Bedford/Boston, Minneapolis, Seattle/American Lake, Sepulveda) are participating with the Bronx and Allen Park VAMCs in the development of a cooperative research project. The initial focus of this study will be to test the efficiency of oral physostigmine in treating the memory and cognitive deficits associated with Alzheimer's disease (AD). Promising data has already emerged from initial work conducted at the Bronx VAMC, and data from a larger sample of patients should help to either confirm or deny the "cholinergic hypothesis" as an explanation for the symptoms of dementia in Alzheimer's disease. This study will also be significant in its standardization of subject selection and assessment/measurement procedures, which will strengthen our ability to compare future AD research findings at these centers.

Question 20B. How much funding is budgeted for this study in FY82 and FY83?

Answer 20B. The Office of Geriatrics and Extended Care has budgeted approximately $3,000 during FY 82 for the purposes of standardizing the administration and establishing the reliability of the assessment procedures. During this period, the collaborating investigators will be submitting a cooperative research pre-proposal to Medical Research Service for merit review.

Question 21A. I understand that health care trainees often resist or are reluctant to accept rotations through wards specializing in geriatric care or other programs which treat primarily aged patients.

How many health care professionals per year does the VA train, and of these, how many receive some training in geriatric care?

Answer 21A. The VA health care system participates in the education of approximately 100,000 trainees per year. Most of these trainees' "core" training is not in geriatrics; however, most trainees learn about geriatrics to the extent that it relates to their particular discipline.

A goal of the VA is to bring geriatrics to the attention of all health professionals. Graduates of the physician and dentist fellowship programs will probably be future coordinators of geriatrically oriented health care. For the academic year 1982-83, the VA is supporting 49 physicians and dentists in geriatric fellowship programs. This compares with 34 physician Fellows in Geriatrics in 1981-82.

In addition, the VA funded special training programs for the associated health professions. During FY 1981-82, for example, 29 clinical nurse specialists and trainees (at the Master's level) in geriatrics and core teams for interdisciplinary team training in geriatrics at nine sites were supported. The 63 participants in these core teams represent medicine, nursing, rehabilitation and occupational therapies, social work, and psychology. These core teams train about 225 students per year and also conduct workshops for about 540 hospital staff members per year.

Ongoing geriatric training to enhance the skills of VA health care staff is provided through numerous continuing education programs at Regional Medical Education Centers (RMECs), Cooperative Health Manpower Education Centers (CHEPs), and Dental Education Centers (DECs), VA Central Office, and continuing education field units.

Question 21B. Do you believe that the medical schools should and do accept some responsibility for helping change such attitudes towards geriatric care?

Answer 21B. Medical schools need to accept responsibility for creating positive attitudes toward geriatric care in health care providers. An increasing number of medical schools are integrating geriatrics into their curriculum, though progress toward this goal does, at times, appear slow.

Question 21C. Have the dean's committees recognized this as a problem, not only for the VA, but also for the students who will in their lifetimes face the growing demand for care of elderly patients?

Answer 21C. Deans committees' minutes reflect ongoing discussion about geriatric issues, both for national and VA needs. Again, however, progress in this domain does sometimes appear slow.

Question 21D. Do you forsee the need to stimulate greater medical school involvement in geriatric care to overcome this prejudice, and, if so, whould their involvement in the GRECCs contribute to this goal?

Answer 21D. Clearly, more support and stimulation would be beneficial. Involvement with GRECCs is one of many potentially useful modalities.

Question 22. What is the fiscal year 1982 funding level for research related to understanding the aging process, and what percentage of the total VA research budget does it comprise?

Answer 22. The FY 1982 level of VA funding for 131 VA Principal Investigators conducting research related to understanding the aging process will approximate $7.7 million. This comprises approximately 6 percent of the total VA Research and Development budget.

Question 23. What are the medical specialties of those who formed the interdisciplinary team training in geriatrics that you mentioned on page 18 of your statement?

Answer 23. The medical and allied health disciplines represented on the ITTG "core team staff" at Sepulveda VAMC include: 1) dietetics; 2) clinical nurse specialist; 3) social work; 4) psychology; 5) occupational therapy; 6) speech pathology; 7) licensed vocational nurse; 8) registered nurse; and 9) nursing assistants. Students and geriatric fellows are active participants with this team.

Question 24A. What formal relationships or information exchanges does the VA have with the National Institute on Aging and the Administration on Aging?

Answer 24A. The VA has several relationships with respect to NIA. They are:

(1) The ACMD for Geriatrics and Extended Care serves on the Advisory Council.

(2) The Office of the ACMD for Geriatrics and Extended Care has subsidized VA GRECC staff to appear at NIA conferences, especially in "Biomarkers of Aging" and "Incontinence."

(3) The VA made a formal presentation on its extended care programs to the NIA Advisory Council at their spring meeting on June 14, 1982.

With respect to the AoA, a VA representative has sat on the AoA Research Committee advisory boards with regularity. In addition, AoA transferred $50,000 to the VA's Office of the ACMD for Geriatrics and Extended care for analysis of hospital based home care data in 1981.

Question 24B. Are these in active operation? Please provide a chronology of interchanges for the last year.

Answer 24B. All relationships are active and ongoing. Contacts are made at regular intervals, usually on a weekly basis.

Question 25A. The director of the National Institute on Aging, Dr. Robert Butler, is leaving his present post soon to head the nation's first full-fledged Department of Geriatric Medicine at Mount Sinai Hospital and Medical School in New York City. Dr. Butler is planning a teaching nursing home in Mount Sinai which he envisions as a key resource for the new Department.

Is a teaching nursing home a concept which the VA is pursuing or interested in?

Answer 25A. A "teaching" nursing home is a concept that the VA is interested in, but not actively pursuing or developing at this time.

Question 25B. Do you plan any involvement or contact with this Department of Geriatric Medicine and specifically with the teaching nursing home through the Bronx VAMC affiliation with Mount Sinai Hospital or otherwise?

Answer 25B. There are no specific plans for contact with the Mount Sinai School of Medicine, Department of Geriatric Medicine, in the immediate future.

Question 25C. Are there any plans for--or is consideration being given to having any participants in the VA geriatric fellowship program rotate through the Department of Geriatric Medicine at Mount Sinai?

Answer 25C. There are no plans for VA geriatric fellows to rotate through this department; however, the option for fellows to take such a rotation does exist.

Question 26A. Alzehimer's disease is one of the tragic, age-related diseases which can be expected to place more demands on the VA as the number of elderly veterans increases. Estimates indicate that 1.5 million people now suffer from Alzheimer's disease.

Please provide the number of veterans per year, for the last 5 years, who were diagnosed at VA facilities as having senile dementia of the Alzheimer's type.

Answer 26A. Answer will be forwarded as soon as data is processed.

Question 26B. Are the needs of Alzheimers's patients sufficiently different from those of other patients that specialized centers—such as Regional VA Centers for Alzheimer's disease similar to your Blind Centers—would be an appropriate way to provide care?

Answer 26B. The implementation of Regional Centers for care of Alzheimer's disease would be premature and inappropriate to the level and kind of care presently required in treating this disease. However, VAMCs with a research and education focus on Alzheimer's disease could enhance and support clinical expertise in diagnosing and managing the disease at each VA medical center. Four of the Geriatric Research, Education and Clinical Centers—Bedford and Boston, MA; Minneapolis, MN; Seattle, WA; and Sepulveda, CA, now have dementia as a primary focus of activity. In addition, several VAMCs have substantial clinical research activities in the area, notably VAMCs at Bronx and Manhattan, New York. As indicated in the answers in later questions, these programs generate substantial research and educational efforts. In addition, several VAMCs are experimenting with specialized inpatient wards such as the one at Montrose, NY. Because much of the care is provided on an outpatient basis and much of the practical treatment consists of helping the family of the veteran to furnish care, it is important that clinical expertise be as widely dispersed as possible. There is wide variation in the quality and approach of professionals to the diagnosis and management of progressive dementia, both within the VA and in the private sector. The VA is developing a program guide for progressive dementia that has as a goal the establishment of a uniform approach and set of objectives for treating the disease. When the guide is completed in FY 1983, we plan to follow its distribution with appropriate training programs.

Question 26C(i). Please comment on the appropriateness of each of the following alternatives for providing care to patients with Alzheimer's disease: nursing home care, day care and home aids.

Answer 26C(i). Alzheimer's disease is a progressive degenerative disease with some clinically distinct stages. In the early and middle stages the patient can usually be cared for at home but needs varying amounts of supervision to assist in orientation and to minimize the possibility of accidents. For such patients, day care and home aids are useful to help the patient as well as the spouse or caregiver. In the terminal stages of the disease, a great deal of nursing care is required as well as more intensive supervision to prevent the patient from wandering off. In short, all of the alternatives are usually needed at one or another stage of the disease, although they are usually not alternatives for the same stage.

Question 26C(ii). To what extent can and does the VA use each of these alternatives?

Answer 26C(ii). The VA makes extensive use of nursing homes, both VA and community for the care of Alzheimer's patients. We have not formally established special programs for management of such patients on a national scale. However, several hospitals have established programs to help the family manage the patient at home. At the Bedford VAMC for example, a chapter of the Association for Alzheimer's Disease and Related Disorders was started for veterans and their families with the active support of VA staff. Some VA hospitals use special wards for diagnosis as well as treatment of such patients. Because different kinds of care are appropriate at different stages of the disease both institutional and non-institutional programs are required.

Question 26D(i). Are there other alternative means of care you consider appropriate for these individuals?

Answer 26D(i). There are intensive research efforts ongoing to develop palliative and potentially curative treatment for memory loss. To the extent that any of these efforts prove successful there will most probably be a new array of possibilities for outpatient treatment. But, at this time the present modalities of care are adequate although there is room for improvement.

Question 26D(ii). What do you see as the VA's role in assisting or providing temporary relief to families in caring for Alzheimer's patients and thus prolonging the period the individual remains outside of nursing homes or other institutions?

Answer 26D(ii). The role of the family in caring for the Alzheimer's patient is central to the success of the treatment of the disease at all stages, and the goal of the VA is to prolong the period that the family can care for the patient. This includes efforts to help the family find help in obtaining respite for themselves. The degree to which the VA could provide temporary institutional care to the patient suffering from dementia to assist the family depends on the medical justification for such care and the availability of resources.

Question 26E(i). Does the VA have the capacity to provide care to veterans suffering from Alzheimer's disease who seek care from the VA?

Answer 26E(i) The VA has the capacity to care for veterans with Alzheimer's disease. Eligibility for care is provided on the same basis as for other nonservice connected diseases.

Question 26E(ii). (if yes) Do you believe the VA will be able to continue to meet this demand over the next twenty years?

Answer 26E(ii). The VA will continue to meet the demand for care within the limitations of our resources. The VA cannot however, provide unlimited institutional care for patients now, nor will it be able to do so in the next twenty years.

Question 26F(i). To what extent has the VA in general and its GRECC programs engaged in research or treatment-oriented projects related specifically to Alzheimer's disease? (Indicate the FTEE and funds committed to this effort).

Answer 26F(i). A priority research area for the GRECCs is the development of a better diagnostic assessment and clinical treatment protocol for Alzheimer's Disease. The Department of Medicine and Surgery has hosted two national conferences for the purpose of developing a research strategy in Alzheimer's Disease, and currently four GRECCs (as described in response to question 20.A.) are participating with the Bronx and Allen Park VAMCs to develop a cooperative study of Alzheimer's disease. In addition to addressing a specific psychopharmacologic hypothesis, such a coopcooperative study would foster development and adoption of uniform diagnostic and assessment criteria, and provide well-defined homogeneous populations for any number of other AD research projects.

During FY 81 eight GRECC principal investigators received $386,000 in research funds (VA and non-VA) for the study of Alzheimer's disease and related disorders. This, of course, represents only a portion of the total VA research effort in AD. Four GRECCs offer specific treatment programs for Alzheimer patients. The Seattle/American Lake GRECC operates an 18 bed inpatient Dementia Unit, and the Bedford, Sepulveda and Minneapolis GRECCs offer long-term outpatient follow-up to AD patients and psycho-social support services to patients' families.

Question 26F(ii). What is the status of these projects?

Answer 26F(ii). All of these projects are in process. As yet, there still is no cure for Alzheimer's disease, although recent findings are providing a rational direction for future research toward reliable diagnosis and efficacious treatment. At present, we are faced with the challenge of determining and establishing appropriate and feasible levels of care for veterans with this disorder.

Question 26F(iii). How high a priority do you attach to this field of research?

Answer 26F(iii). Alzheimer's disease represents a significant challenge and high research priority for four of the GRECCs.

Question 26F(iv). What mechanisms exist to ensure that lessons learned through these projects are shared with other health care providers—both in and outside of the VA—caring for Alzheimer's patients?

Answer 26(iv). The mechanisms described in response to Question 17A apply equally to the dissemination of information concerning the effective diagnosis and treatment of Alzheimer's disease. In addition, the extent of the problems presented by this disease to patient, family and hospital staff creates an environment that virtually assures rapid diffusion of information concerning therapeutic advances.

Question 27A. I understand that individuals over the age of 75 require more of certain types of specialized medical care -- such as podiatry -- than younger individuals.

To what extent do these older individuals require more podiatric care than younger individuals?

Answer 27A. Geriatric patients require podiatric evaluation and treatment more often than do younger patients. It is well known that geriatric patients often have decreased circulation especially to their lower extremities, a higher incidence of neurological diseases, and the many pedal manifestations such as reheumatoid arthritis, gout, and Diabetes Mellitus. In addition, the years of ambulation have taken their toll and created intrinsic foot pathology.

Question 27B.

How many podiatrists does the VA currently employ? (Please give a breakdown according to the fraction of full-time service for which they are employed).

Answer 27B.

Fifty-six full-time and 47 part-time with an average FTEE of 70.

Question 27C.

Dr. Custis, I understand you had approved the hiring of 20 additional podiatrists in FY '82.

(i) Is that correct?

(ii) What is the status of that proposal?

(iii) If the status has changed, what are the reasons that prompted you to invalidate your initial decision?

Answer 27C.

The Chief Medical Director approved a hiring ceiling of fifteen additional podiatrists in FY 1981, contingent upon funding from existing medical center allocations. Therefore hiring of podiatrists is a medical center decision based on availability of local funds and priority of programs/staffing needs. Although many of the fifteen approved FY 1981 slots were filled in FY 1981, the hiring for some of these positions was not accomplished until FY 1982.

Question 28. Mr. Westall, in his testimony, cited an example of efforts to outplace Bay Pines VAMC domiciliary residents to illustrate the need for closer working relationships between the Department of Medicine and Surgery and the Department of Veterans' Benefits. He stated:

> Three of these [domiciliary residents] had to return [to the domiciliary] because they were caught in a "Catch 22" situation of losing benefits. That benefit that I refer to is that they were in the area of 20 percent service-connected disability and that had been increased to 100 percent while they were in a very sheltered domiciliary environment.
>
> After a great effort [by] the staff to outplace these people, DVB removed their benefits. Now that's a legal requirement for DVB to do that.

It appears that Mr. Westall was referring to the increase to a total disability rating that a service-connected veteran receives after 21 days of hospitalization. However, according to VA regulations (38 CFR, sections 4.29 and 4.30), this increased rating is given only to a veteran requiring certain hospital observation or treatment for a period in excess of 21 days for a service-connected disability or convalescence following certain hospital treatment for such a disability.

Question 28A. Do domiciliary residents fall into either of these categories, and thus qualify for total disability compensation?

Question 28B. [If not] How else can the situation Mr. Westall outlined be explained?

Answers 28A and 28B.

In checking with the staff at the Veterans Administration Medical Center at Bay Pines, Florida, on the examples Mr. Westall gave in his testimony, there was one veteran who was hospitalized for his service-connected disability and required a protracted period of convalescence. During that convalescence, he was transferred to the domiciliary and subsequently outplaced to an independent living residence. On termination of his convalescent period, the veteran's VA monetary benefits were reduced to the monetary award commensurate with his service-connected rating. The veteran lacked adequate financial resources to continue in the independent living residence and was accepted back in the domiciliary. In other situations, veterans in receipt of VA pensions obtain modest or part-time jobs to supplement their income which then gives them adequate financial resources to live in the community. If their earned income exceeds the VA pension maximum income level, the pension is terminated or, if they lose their jobs, the pension alone is inadequate to maintain an independent residence. These veterans, with pensions as their sole income, cannot financially afford to live in an independent residence and request return to the domiciliary.

Domiciliary residence, in and of itself, would not qualify a veteran for the temporary total evaluation under either 38 CFR 4.29 or 4.30. Treatment or observation in a VA hospital for a period in excess of 21 days is required for consideration under 38 CFR 4.29. This temporary total evaluation may be extended for one or more months following discharge if a period of convalescence is required. Surgery necessitating posthospital convalescence, severe postoperative residuals or immobilization of a major joint by cast, without surgery, is required for consideration under 38 CFR 4.30. A temporary total evaluation based on a need for convalescence would be in order whether the veteran is convalescing in a VA domiciliary or in his or her own home.

Chairman SIMPSON. The next group is Ewald Busse, chairman of the Veterans' Administration Geriatrics and Gerontology Advisory Committee; associate provost and dean of the Medical Allied Health Education, Duke University School of Medicine, Durham, N.C.; and Murray Raskind, director of the Seattle/American Lake Geriatric Research, Education, and Clinical Center, GRECC as we call them, and the Veterans' Administration Medical Center in Seattle.

It is nice to have you gentlemen with us. Please proceed, thank you.

TESTIMONY OF DR. EWALD W. BUSSE, CHAIRMAN, VETERANS' ADMINISTRATION GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE AND ASSOCIATE PROVOST AND DEAN, MEDICAL ALLIED HEALTH EDUCATION, DUKE UNIVERSITY SCHOOL OF MEDICINE, DURHAM, N.C.; AND DR. MURRAY A. RASKIND, DIRECTOR, SEATTLE/AMERICAN LAKE GERIATRICS RESEARCH, EDUCATION, AND CLINICAL CENTER [GRECC], VETERANS' ADMINISTRATION MEDICAL CENTER, SEATTLE, WASH.

Dr. BUSSE. Thank you very much.

I wish to express my appreciation for the opportunity to appear before this very important committee. I also want to say that your opening remarks do reflect the indepth knowledge you have of this problem. It is gratifying to work with a group who really does understand the complexities of the problem we are facing trying to provide adequate care for the aging veteran.

And, quite similarly, Senator Cranston reflected the same depth of knowledge and I did very much appreciate it.

I will limit my remarks to a few selected items that are expanded within the written statement that I presented to you. I do believe I should start with a comment about the Geriatrics and Gerontology Advisory Committee of the Veterans' Administration.

This has been a very effective group. It is a well balanced representation of scholars and scientists and clinicians as well as representation of the public and of the veterans themselves.

I am very grateful for the effort they have put into the assigned tasks.

Our first task, which was cited in the law you referred to earlier, was to take a careful look at the GRECC's. We have completed site visits to all of the GRECC's and we are in the process of putting together a composite report.

However, I do think it's very important that I say as an individual that I believe the concept of GRECC's that was developed by Paul Haber I believe back in 1973 and implemented in 1974 was clearly a creative excellent idea.

It is unfortunate that there are only eight GRECC's in existence. Public Law 96-330 does provide for as many as 15, but lack of additional funds have made it prohibitive to attain this number.

When one visits GRECC's it's clear they've had a positive affect upon the host facility and as every other type of program there are areas which I wish were better. All too often it's because of a lack of funding.

However, I do believe that the idea of establishing GRECC's was superb and it has achieved many of the objectives which Dr. Haber and his colleagues envisioned at that time.

The Committee on Geriatrics and Gerontology is moving into the other important charge looking at the service component and alternatives to care and innovative care that may be useful to providing the care of the aging veteran.

I do believe I should mention in this regard the problem of funding of aging of research within the VA. I recognize that money is limited and choices have to be made, but we should also recognize that it does limit very seriously the amount of aging research that can be conducted.

The funds, in effect, have been shrinking and it is always very difficult to make judgments as to how these funds can be properly allocated.

It would be desirable if there could be an amount of money that clearly was earmarked so that some of these demonstration and evaluation projects which, in my opinion, need to be carried out could be adequately funded for a period of time.

I think it would be a good investment and good long range planning, say, perhaps 5 to 7 years.

I think Senator Simpson has said on a number of occasions this morning that we have to look at both cost effectiveness and cost beneficial aspects of these various types of approaches.

The Veterans' Administration, in my opinion, is an extremely important national resource. The population change that is confronting us is not only within the Veterans' Administration, it permeates all of our society.

I do believe the Veterans' Administration is very unique in that it has a system in place; that it has the capacity to follow individuals; and I do not believe that our Nation can afford to lose the Veterans' Administration as a major resource to examine how to better take care of the elderly.

I know that there are those who will say that the VA population has a defect in the fact that it does not include a substantial female population. I believe by sensible research design the lack of females can be in part met.

There are other things which I wish to mention about the GRECC's, of course. There are some unusual requirements within the existing law, that is Public Law 96-330, that does make it somewhat cumbersome. I do believe that a greater flexibility would be much more in order than always holding to certain regulations that limit the development to new ideas.

I was asked specifically to talk about a possible alternative approach to long-term care; namely, the case management model. I believe that others who will appear here this morning have had experience in this area so I'll make my remarks to it brief.

In my opinion, the case management model is usually designed for those who are seriously impaired, sometimes referred to as the frail elderly. These are the individuals who have multiple diseases and are often complicated by social economic problems of serious magnitude.

They require a multitude of services in order to function properly, not only health but socioeconomic support. I do believe that these services have to be coordinated.

It does require a coordination of those services provided by the VA and by the community. It is not an uncomplicated task, but I do believe it is a very worthwhile one.

To cut my remarks even shorter, I would say that the case management approach be looked at more extensively by the Veterans' Administration. This approach is currently in use within the VA.

Just within the last week I've had an opportunity to talk with several individuals who are currently engaged in this type of activity.

I would like to also suggest that the Veterans' Administration consider taking advantage of the possibility of using volunteers.

I am impressed with how the various organizations of the veterans—American Legion and other ones like them—are quite willing to give time and effort. They have a great deal of competence. And I think we would be overlooking a major resource if we did not seriously consider utilizing this volunteer possibility in this particular effort.

I will conclude by saying I agree that we need more data. I know that Dr. Custis mentioned this. The Veterans' Administration is fully cognizant of this.

I feel quite confident that by the spring of next year this committee that I represent as well as the Veterans' Administration will come up with some meaningful data to present to you.

Thank you again for the opportunity of talking with you.

Chairman SIMPSON. Thank you very much, Dr. Busse.

Dr. Raskind, please.

Dr. RASKIND. I, too, would like to thank this committee for providing the opportunity to testify concerning the health-care programs and policies which affect the needs of the aging veteran.

My remarks are based on my experience as a clinical geriatrician and a geriatric psychiatrist as well as my experience as an educator and clinical researcher. I have been Director of the Geriatric Research, Education, and Clinical Center—better known as the GRECC—at the Seattle and American Lake VA Medical Centers for the past 5 years and I'm currently associate professor of psychiatry and head of the division of geriatric psychiatry at the University of Washington School of Medicine.

I'll try to focus upon my perceptions of the special health-care needs of the aging veteran and will attempt to explain the role of the GRECC in meeting these needs.

That the growing population of aged veterans is placing progressively increasing demands on the VA health-care system is evident to anyone who visits a VA medical facility. This care must be compassionate, qualitatively excellent and as cost-effective as possible.

It should be emphasized that, at least in my opinion, the health-care problems of the geriatric patient often differ from those of the younger patient. These problems include multiple chronic medical and surgical diseases which are not readily amenable to high-technology treatment techniques; intellectual and functional deterioration secondary to psychiatric disorders such as dementia of the Alzheimer's type; and major depressive disorder and complicated social and environmental problems which call for outreach efforts to the family and the community as well as ongoing outpatient followup care.

I am an American-trained physician. Although the American physician is probably the best trained in the world, this training—as has mine—primarily occurred in high-technology acute care hospital settings and often leave the physician inadequately prepared to manage the multiple problems of the geriatric patient and to lead the necessary multidisciplinary approach to patient management.

I want to stress this multidisciplinary approach. I should also tell you that I am not exclusively a psychiatrist. I was trained for several years as an internal medicine specialist in New York City at the Columbia-Harlem Hospital Center.

When I told my grandmother, who is 91 years old and now lives in Rochester, N.Y., and still doing quite nicely, that I was changing my training from internal medicine to psychiatry, she hesitated a moment and looked at her grandson, the doctor, and didn't say a thing for 30 seconds; didn't even say anything for 45 seconds, which for her was a record; and finally said, "What's the matter, Murray, weren't you happy being a doctor?" [Laughter.]

It's a true story. I tell the anecdote not to take up the committee's time, but to emphasize that geriatrics is especially attractive and has to be sold, if you will, to those and other health-care providers who have been trained and have an interest in multiple disciplines because the care needs of the geriatric patient demand that we look at the patient in a multifaceted way.

Let me touch on the individual facets of the GRECC—the clinical, educational, and research. And I'll talk about them separately though obviously they're intertwined.

Clinically, at the Seattle/American Lake GRECC, we have four programs based at two separate VA medical centers which we think represents a spectrum of multidisciplinary care. These clinical programs also serve as sites for teaching health-care professionals and for the ongoing clinical research studies in our program.

We have a geropsychiatry evaluation unit which provides intensive diagnosis and treatment to elderly veterans with behavioral disorders; a multidisciplinary consultation team which brings the skills of the internist, psychiatrist, the nurse, the psychologist, the social worker, the podiatrist, and other disciplines to bear upon the elderly patient with multiple complex problems; and an outpatient clinic which provides the same type of multidisciplinary care.

In addition, we have a long-term care unit dedicated to patients with dementia of the Alzheimer's type, a disease which has been stressed repeatedly at this hearing. This unit again is a care, education, and a research facility.

The utility of the geriatric evaluation units of the GRECC's has already been demonstrated in that they improve diagnosis and treatment and at least appear to have decreased rates of institutionalization.

At the Sepulveda GRECC, a formal evaluation of the geriatric evaluation unit is underway.

On education: Before specific geriatric skills can be taught, enthusiasm and excitement about geriatric care must be generated.

I want to emphasize this point. When I was in medical school, geriatrics was something to be shunned at almost any cost by medical students and other medical trainees. I think that some of the pioneering efforts of Dr. Busse in psychiatry and other leaders in medicine have started bringing geriatrics into the mainstream of American medical training.

I think that the GRECC's, since their inception, have been very helpful in advancing geriatrics from their peripheral position in American medicine into the mainstream of academic medical training and community medical education; and we intend to pursue this.

The research efforts need to be stressed and stressed strongly. It's my opinion that despite innovative clinical and educational efforts, substantial improvements in the health care of the aging veteran can only come from advances in research.

Until we have specific preventive and/or therapeutic treatments for such devastating illnesses as dementia of the Alzheimer's type, degenerative vascular disease, and adult onset diabetes mellitus demands on the health-care system for devoting more and more resources to maintenance care of the elderly veteran can only increase.

At the Seattle/American Lake GRECC we have made significant research advances in studies of hormonal sleep rhythm disturbances in Alzheimer's disease, treatment of disabling depression in atherosclerotic heart disease patients, and neuroendocrine control mechanisms in aging and diabetes.

Other GRECC's have made research contributions in degenerative neurologic diseases, memory impairment with aging, cardiovascular and pulmonary disease, diabetes, and immunologic functions in aging.

Finally, the GRECC's have a unique opportunity to lead major cooperative research studies within the VA medical system.

The first such GRECC cooperative study is now beginning to address diagnostic, pharmacotherapy, and neuroendocrine issues in dementia of the Alzheimer's type; a disease which causes severe disability in tens of thousands of aging veterans.

It's my opinion that the VA has the clinical resources and the patient population vital to success of such large cooperative efforts.

These research efforts together with GRECC clinical and educational programs are already improving the health care of the aging veteran and promise to do even more in the future.

Thank you for this chance to testify.

Chairman SIMPSON. Thank you very much.

I appreciate the remarks that both of you bring to the committee.

I had several questions, but I think I have another conflict coming on with another committee on which I serve—Environment. So I'm going to submit my questions in writing to you.

I appreciate your being here and what you're doing with these novel systems of the GRECC and the case management model. I'm curiously interested in how that will work and the coordination with VA health care and community based organization services for the aged.

Those are some of the questions I will ask. I just regret that I thought I'd let you go a little longer and then I never dreamed you'd go that long.

You went over 5 minutes, each of you, but I was interested in what you were saying and I will submit those questions in writing.

I thank you very much for sharing your background with us; and thank you very much.

Dr. **Raskind**. Thank you.

Dr. **Busse**. Thank you.

[The prepared statement of Dr. Ewald W. Busse, chairman, Veterans' Administration Geriatrics and Gerontology Advisory Committee; associate provost and dean, Medical Allied Health Education, Duke University School of Medicine, Durham, N.C., and his response to written questions submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, and prepared statement of Dr. Murray A. Raskind, director, Seattle/American Lake Geriatric Research, Education, and Clinical Center [GRECC], Veterans' Administration Medical Center, Seattle, Wash., and his response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF DR. EWALD W. BUSSE, CHAIRMAN, VETERANS' ADMINISTRATION GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE; ASSOCIATE PROVOST AND DEAN, MEDICAL ALLIED HEALTH EDUCATION, DUKE UNIVERSITY SCHOOL OF MEDICINE, DURHAM, N.C.

I am Ewald W. Busse, J. P. Gibbons Professor of Psychiatry and Associate Provost and Dean of Medical and Allied Health Education, at Duke University Medical Center, Durham, North Carolina. I am currently serving as Chairman of the Geriatrics and Gerontology Advisory Committee of the Veterans Administration.

The Geriatrics and Gerontology Advisory Committee of the Veterans Administration was established by Public Law 96-330. This Advisory Committee was chartered as of January 1, 1981. The first meeting of this Committee was held on May 21 and 22, 1981 in Washington, D. C. There are thirteen members of this Advisory Committee representing a broad spectum of disciplines and interests relevant to carrying out the mission of the Advisory Committee. A list of the members is attached. (Appendix 1)

According to PL96-330, the Advisory Committee must prepare by April 1, 1983 a report with respect to its findings and conclusions regarding the status of the geriatric research, education, and clinical centers. This report is also to include recommendation for other geriatric services including extended care and is aimed at meeting the needs of eligible older veterans. In accord with the PL96-330 the first task of the Committee was the evaluation of the existing eight Geriatric Research, Education, and Clinical Centers (GRECCs). This evaluation process which included site visits has been completed and the composite report is in the process of formulation.

The Committee is now turning its major attention to assessing the capability of the Veterans Administration to provide high quality geriatric extended and other health care services to eligible veterans. The Advisory Committee is to assess the current and projected needs of the eligible older veterans provided by the Veterans Administration and to assess its activities and plans to meet the needs of eligible older veterans. The Committee as a whole meets not less than twice a year. Subgroups and subcommittees have been established to carry out the assigned functions of evaluation and reporting.

My statement here today does not represent the views of the entire Committee or any other individual members of the Committee. Consequently it is not a preliminary statement nor does it select material of the forthcoming report of the Geriatrics and Gerontology Advisory Committee.

This Senate Committee is aware of the serious situation faced by the Department of Medicine and Surgery because of the projected rapid increase in the number of veterans over age 65. The number of veterans over age 65 will increase from about 3 million in 1980 to 5.5 million in 1986, to 7.7 million in 1990, and up to 9 million in the year 2000. These numbers represent an increasingly large percentage of the older male population of the United States. As of 1980, veterans 65 years of age represented 28.7% of all males, but by 1990, it will be 64.1%, and by the year 2000, 70.80%. These aging veterans like nonveterans will experience a rapid increase in the number of acute and chronic illnesses requiring both short- and long-term care.

The Veterans Administration as an Important National Resource

There is no doubt in my mind that the Veterans Administration and the population of veterans that they serve provide a unique and important resource for studying the aging American and the proper choice of health care for these individuals. However, it should be recognized from the outset that there are limitations in these studies; for example, only between 2 and 2.5% of all veterans are females. Furthermore, the 3 million veterans that utilize Veterans Administration health resources are different in some respects from the 27 million veterans that do not utilize the Veterans Administration. In my opinion the characteristics of the 3 million veterans that do utilize the VA make them a higher risk group. These unfortunate characteristics may actually make the studies more valuable as they will emphasize the importance of both cost-benefit (outcome measured in quality and quantity of life)and cost-effectiveness studies (outcome in a dollar value).

To conduct adequately controlled applied research that includes the demonstration projects and alternatives to the care of the elderly veteran, it would be necessary to have the full cooperation of the Congress of the United States and the Administration. Such studies would be seriously reduced in their value if during the course of the study, entitlement or eligibility for health care would be altered. It would also require stability in a number of critical factors including assurance of funding until completion of the project.

Geriatric Research, Education, and Clinical Centers

In 1973, Dr. Paul Haber of the Veterans Administration conceived the idea of developing "centers of excellence whose goals would be to achieve professional legitimacy by attracting outstanding professionals to teach and conduct research on aging in a clinical context and as a result have a positive impact on the care of older veteran patients." To test the validity of this concept, the Department of Medicine and Surgery of the Veterans Administration decided to establish a limited number of units based in the Veterans Administration Medical Centers designated as a Geriatric Research, Education, and Clinical Center. During the period from 1974 to 1977, eight of these demonstration centers were established. Although PL96-330 authorizes the establishment of up to 15 such centers, no new centers have been established because of lack of funding. The GRECCs are located at the Boston, Massachusetts Outpatient Clinic and the Veterans Administration Medical Centers in Bedford, Massachusetts; Little Rock, Arkansas; Los Angeles, California; Minneapolis, Minnesota; Palo Alto, California; St. Louis, Missouri; Seattle, American Lake, Washington; and Sepulveda, California.

All of the GRECCs have been site visited by members of the Geriatrics and Gerontology Advisory Committee. In 1979, an assessment of the progress and status of the GRECCs was conducted by a team composed of Veterans Administration personnel. The "in house" team visited each of these GRECCs. Consequently, the Geriatrics and Gerontology Advisory Committee had available to them prior observations and recommendations. The Veterans Administration "in house" site visit team made a number of recommendations, and many of these changes resulted in alterations within the GRECCs.

Title III of PL96-330 formalizes the GRECC program and clarifies its function within the Department of Medicine and Surgery, Health Care Delivery System, in a broader context than previously existed. (Appendix 2) Paragraph D states: "The administrator shall assure that the center of each facility designated under such paragraph is receiving adequate funding to enable each center to function effectively in the areas of geriatric research, education, and clinical activities."

A Veterans Administration Medical Center designated as a host for a GRECC must fulfill certain criteria.

1. The host facility must be one affiliated with an accredited medical school involved in education and training in geriatrics.
2. Affiliate with a nursing school or allied health programs. (Note: A GRECC involvement is not required for nursing and allied health even though the host VAMC must have such affiliations.
3. Establish rotation for residents from the affiliated schools through the GRECC and other facilities such as the nursing home, extended care, or domiciliary units.
4. Arrange for education and training of nursing or allied health personnel through the nursing home extended care or domicilary unit.
5. Establish a local policy making an advisory committee for the GRECC program.

It is my opinion that the concept of GRECC formulated in 1973 has proven to be correct. The centers have attracted a cadre of excellent clinicians and scientists. The research concerned with the aging processes and the problems of the elderly have made a significant contribution to gerontology and geriatrics. The existence of a GRECC within a facility is a very positive factor in focusing upon the problems of the elderly, and the impact of the research, educational, and clinical activities of the GRECCs has favorably affected the care of older veterans.

The Funding of Research

The funds that support research conducted in the eight GRECCs were taken from funds originally appropriated for research in general within the Department of Medicine and Surgery. This was necessary because no funds were specifically appropriated for GRECC research. Consequently the fate of the budget for general research becomes crucial to the conduction for research related to the aging veteran.

The VA Department of Medicine and Surgery research expenditures in fiscal year 1981 were 140 million dollars. That figure was reduced to 128 million dollars in fiscal year 1982, and the figure proposed for 1983 is 138 million dollars.

The 128 million figure for fiscal year 1982 represents 1.8% of the total DM&S budget. Of the 128 million about 3.3 million is devoted to aging research. This represents 2.6% of the research budget. It is evident that this budget is inadequate as the research that is needed to minimally satisfy the purposes set forth in Title III, PL96-330 cannot be achieved. It is my opinion that if these goals are to be realized, additional funds for aging research must be expended for a period of five to seven years which will support clinical and applied research including demonstration and evaluation projects.

The Implementation of a Case Management Model for Providing VA Health Care and Social Support Services for the Aging Veteran

For a number of years the urgencies raised by the complexity and increasing costs of long-term care for functionally impaired persons such as the impaired elderly veterans have focused attention on the possibility of coordinating the numerous and diverse resources that exist within a community or system such as the Veterans Administration so that the patient or client is provided access and adequate services from these resources. (See Appendix 3.) Although the basic objective is the same, there are at least two important case management models and numerous variations within these two major groups. First is the recognition that the agencies themselves must cooperate and be fully knowledgeable as to the services that are offered and the gaps that exist. This is sometimes referred to as the macro management model. Such functions are often carried out by community coordinating councils for the aging. At the micro level, approach can be through a channeling agency, that is, a single point of entry, that is also responsible for coordination. Often this coordination is conducted by an individual case manager who is assigned to an individual. Upon entry into a channeling agency, the individual does have a thorough assessment of the health and social status as well as (his) needs and then an attempt is made to meet these needs by coordination of many services. Although it adds costs, it is assumed that the coordinating service, that is, one of the case management models, is more cost-effective as well as cost-beneficial. . . . .

There have been a number of demonstration evaluation projects based upon the "case management model." One approach that should not be ignored within the Veterans Administration is the use of trained volunteers to serve as case managers. This is particularly appealing to me as useful in the Veterans Administration as there undoubtedly will be a large number of elderly veterans who are quite capable of functioning effectively and assisting the impaired veteran and thereby reducing the cost.

It is my impression that modifications of the case management model already are in operation within the Veterans Administration. In some instances the Veterans Administration facility has taken the leadership in developing this broad approach and has become closely linked with community resources. I believe that this should be encouraged.

Long-Term Health Care Data

Often the lack of useful data that is systematically collcted is not available so that it is most difficult to plan for the type and size of services and resources that are needed to develop alternatives to institutional care. In collecting this data it is necessary to emphasize the social and economic as well as medical aspects of the illness and disability. In persons who require long-term care, they seldom have a single medical diagnosis. In addition, people respond differently although they have the same diagnosis because of personality characteristics, social and economic influences, family and supporting persons within the environment. To attempt to correct this deficiency of data, the Office of Health Research, Statistics, and Technology of the National Center for Health Statistics developed a system of data collection called "Long-Term Health Care Minimum Data Set." The National Committee on Vital and Health Statistics recommends that all public and voluntary reporting services for long-term care, clients, and services collect the minimum set of information they develop. This minimum data set has been designed primarily for providers who specialize in long-term care. It is designed to complement not duplicate the information that normally will be available from the facilities and manpower data sets that also are being sponsored by the National Committee on Vital and Health Statistics. The Veterans Administration is aware of the necessity of having data which can be generalized in a broad population and are collecting some data. Lack of funds is a serious handicap. Such information is needed by the Committee on Geriatrics and Gerontology.

The Veterans Administration's contribution is primarily a response to the recommendation of the Technical Consultant Panel of the Minimum Data Set that "Studies should be made to test the reliability, validity, feasibility, acquisition costs and utility of the Long-Term Care Data Set."

Attachments 3

Appendix 1

VETERANS ADMINISTRATION

GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE

MEMBERSHIP MAY 1982

1. Richard C. Adelman, Ph.D.
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2. Jack Botwinick, Ph.D.
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3. Ewald W. Busse, M.D. (CHAIRMAN)
Associate Provost & Dean
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VETERANS ADMINISTRATION

GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE

MEMBERSHIP MAY 1981

7. Mr. Robert E. Lyngh
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Appendix 2

Excerpt From
P. L. 96 - 338
Title III - Geriatric Research and Care

"(C) The Administrator may not designate any health-care facility as a location for a center under subparagraph (A) of this paragraph unless the Administrator, upon the recommendation of the Chief Medical Director, determines that the facility has (or may reasonably be anticipated to develop)--

"(i) an arrangement with an accreditaed medical school which provides education and training in geriatrics and with which such facility is affiliated under which residents receive education and training in geriatrics through regular rotation through such center and through nursing home, extended care, or domiciliary units of such facility so as to provide such residents with training in the diagnosis and treatment of chronic diseases of older individuals, including cardiopulmonary conditions, senile dementia, and neurological disorders;

"(ii) an arrangement under which nursing or allied health personnel receive training and education in geriatrics through regular rotation through nursing home, extended care, or domiciliary units of such facility;

"(iii) the ability fo attract the participation of scientists who are capable of ingenuity and creativity in health-care research efforts;

"(iv) a policymaking advisory committee composed of appropriate health-care and research representatives of the facility and of the affiliated school or schools to advise the directors of such facility and such center on policy matters pertaining to the activities of such center during the period of the operation of such center, and

"(v) the capability to conduct effectively evaluations of the activities of such center.

"(D) Prior to providing funds for the operation of any such center at a health-care facility other than a health-care facility designated under subparagraph (B)(i) of this paragraph, the Administrator shall assure that the center at each facility designated under such subparagraph is receiving adequate funding to enable such center to function effectively in the areas of geriatric research, education, and clinical activities.

Appendix 3

Classification of Programs and Facilities Available to the Aging Veteran

1. Hospital Programs
    - A. General Medical and Surgical
    - B. Intermediate Level Care
    - C. Psychiatric
2. Institutional Extended Care
    - A. Nursing Home Care
    - B. Community Nursing Home Care
    - C. Domiciliary Care
    - D. State Veterans' Hospitals
3. Noninstitutional Extended Care
    - A. Personal Care Home
    - B. Hospital-based Home Care
    - C. Congregate Housing
    - D. Geriatric Day Care
    - E. Senior Centers
    - F. Ambulatory Care
    - G. Dentistry
    - H. GRECCs (Geriatric Research, Education, and Clinical Centers)

Not every facility or service listed above is available in every VA hospital or medical center.

RESPONSE OF DR. EWALD W. BUSSE, ASSOCIATE PROVOST AND DEAN OF MEDICAL AND ALLIED HEALTH EDUCATION, DUKE UNIVERSITY MEDICAL CENTER, DURHAM, N.C., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question. Dr. Busse, you stated at the hearing that "some unusual requirements within the existing law, that is Public Law 96-330, . . . make it somewhat cumbersome." You further stated you believed "that a greater flexibility would be much more in order than always holding to certain regulations when in a period of trying to develop new ideas."

A. What requirements and regulations have you found cumbersome? Please illustrate your point with some examples.

B. What changes in the law or regulations would you recommend to provide needed flexibility?

Answer.

I indicated that in Public Law 96-330 there are requirements imposed upon the Geriatric Research, Education and Clinical Centers that at times are cumbersome. Furthermore, I indicated that certain regulations interfered with the flexibility which is necessary in developing new ideas.

To explain why I believe some of the requirements are constraining and cumbersome, I would like to review the development of the Geriatric Research, Education and Clinical Centers (GRECCs) of the Veterans Administration. In 1975, the first GRECC was established and ultimately eight were funded. The aim was to influence care for the aged throughout the system by creating focal points for research, provide experimentation with improvements in delivery of care, and contribute to education. There was limited funding at that time and there is limited funding today. The objective, which was entirely correct, was to first develop basic research and clinical investigation. Education and services to all of the elderly are important but emphasis was correctly placed upon research and experimentation. Funds simply did not exist to adequately support all of the objectives.

Public Law 96-330 requires that every GRECC give equal weight to research, education and patient care. Furthermore, it requires that students from various affiliated health-profession schools rotate through the long-term care unit associated with the host Veterans Administration medical center and have a learning experience within the GRECC. Not all of the host centers possess the long-term care facilities of the type specified in the law.

I certainly do not object to giving appropriate weight with additional funding to education and clinical activity, but if the clinical investigations and the basic research are reduced by redistribution of the current funds, the GRECCs will no longer exist. Austerity will be with us for many years to come and I do not believe the Veterans Administration will have the financial resources or the facilities that will permit the GRECC and the host institution to give equal weight to all of these objectives. The VA should decide how to best utilize their limited resources.

Public Law 96-330 requires an assistant chief medical director to be responsible for all of the geriatric activity specified in the law. It is my belief that this is not at a sufficiently high level. The Chief Medical Director should assign this responsibility to his Deputy Chief Medical Director. At this highest level it would eliminate the confusion that arises when separating acute from long-term care and would assure the integration of service, education and research.

Therefore, I believe that modification of the law is in order. I believe that this could be best accomplished by you and your staff working with the Chief Medical Director and other appropriate individuals in the Department of Medicine and Surgery of the Veterans Administration.

PREPARED STATEMENT OF DR. MURRAY A. RASKIND, DIRECTOR, SEATTLE/AMERICAN LAKE GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTER (GRECC), VETERANS' ADMINISTRATION MEDICAL CENTER, SEATTLE, WASH.

I would like to thank this honorable committee for providing the opportunity to testify concerning the health care programs and policies which affect the needs of aging veterans. My remarks will be based on my experience as a clinical geriatrician and geropsychiatrist, as well as my experience as an educator and clinical researcher. I have been Director of the Geriatric Research, Education and Clinical Center (GRECC) at the Seattle and American Lake VA Medical Centers for the past five years, and am Associate Professor of Psychiatry and Head of the Division of Geriatric Psychiatry at the University of Washington School of Medicine. I will focus upon my perceptions of the special health care needs of the aging veteran and will attempt to explain the role of the GRECCs in meeting these needs.

That the growing population of aged veterans is placing progressively increasing demands on the VA health care system is evident to anyone who visits a VA medical facility. The care of these elderly veterans must be compassionate, qualitatively excellent and as cost effective as possible. It should be emphasized that the health care problems of the geriatric patient often differ from those of the younger patient. These problems include multiple chronic medical and surgical diseases which are not readily amenable to high technology treatment techniques; intellectual and functional deterioration secondary to psychiatric disorders such as dementia of the Alzheimer's type and major depressive disorder; and complicated social and environmental problems which call for outreach efforts to the family and the community as well as ongoing outpatient followup care. Although the American physician is probably the best trained in the world, this training has primarily occurred in high technology acute care hospital settings and often leaves the physician inadequately prepared to manage the multiple problems of the geriatric patient and lead the necessary multidisciplinary approach to ongoing patient management.

It is the mission of the GRECCs to develop centers of excellence in geriatrics which will promote the health care of the aging veteran. Each GRECC has a clinical, an educational, and a research component. These components will be discussed separately for purposes of clarity, but are mutually interdependent and entwined in reality.

Clinical: The Seattle/American Lake GRECC has four clinical programs based at two separate VAMCs which represent a spectrum of care. These clinical programs also serve as sites for teaching and clinical research. Among these units are a geropsychiatry evaluation unit, which provides intensive diagnosis and treatment to elderly veterans with behavioral disorders; a multidisciplinary consultation team which brings the skills of the internist, the psychiatrist, the nurse, the psychologist, the social worker, the physiatrist and other disciplines to bear upon the elderly patient with multiple complex problems; a multidisciplinary outpatient clinic which provides both outpatient evaluation and long term follow up care to community based patients; and a long term care unit dedicated to patients with dementia of the Alzheimer's type. Of course, the efficacy and ultimately the cost effectiveness of these model clinical programs are being evaluated by health services research. The utility of GRECC geriatric evaluation units has already been demonstrated in that they have improved diagnosis and treatment, and have decreased rates of institutionalization. At the Sepulveda GRECC, a formal evaluation of the Geriatric Evaluation Unit is underway.

Education: Before specific geriatric skills can be taught, enthusiasm and excitement about geriatric care must be generated. One of the most significant accomplishments of the GRECCs has been their ability to help advance geriatrics from a low prestige peripheral position in American medicine into the mainstream of academic medical training and community medical education. Each of the Seattle/American Lake GRECC clinical units is a setting for educating medical students, residents, nursing students and other health care trainees from the University of Washington, and for continuing the education of career health care professionals within the VA. Furthermore, our GRECC has been instrumental in incorporating preclinical and clinical courses in geriatrics into the University of Washington School of Medicine curriculum. The GRECC has primary responsibility for the University of Washington geriatric psychiatry fellowship program (NIMH funded) and psychiatry residents and psychology interns regularly rotate through GRECC clinical training settings. In addition, GRECC staff have travelled to every VAMC in its district and many VAMCs outside of its district to present educational programs during FY '81. Also, GRECC staff travel monthly to each of the two Washington State Soldier's Homes to present educational programs and perform patient care consultations. The GRECC has a strong commitment to continuing medical education at both the local and national level, having presented geriatric educational programs to thousands of health care professionals during FY '81. By publishing and distributing the quarterly GRECC Newsletter, the GRECC has disseminated new knowledge in geriatrics and gerontology to every VA medical facility in the nation.

Research: Despite innovative clinical and educational efforts, it is my opinion that substantial improvements in the health care of the aging veteran can only come from advances in research. Until we have specific preventive and/or therapeutic treatments for such devastating geriatric illnesses as dementia of the Alzheimer's type, degenerative vascular disease, and adult onset diabetes mellitus, demands on the health care system for devoting more and more resources to maintenance care of the elderly veteran can only increase. The Seattle/American Lake GRECC has made significant research advances in studies of hormonal and sleep rhythm disturbances in Alzheimer's dementia, treatment of disabling depression in atherosclerotic heart disease patients, and neuroendocrine control mechanisms in aging and diabetes. Other GRECCs have made research contributions in degenerative neurologic diseases, memory impairment with aging, cardiovascular and pulmonary disease, adult onset diabetes mellitus and immunologic function in aging.

Finally, the GRECCs have a unique opportunity to lead major cooperative research studies within the VA medical system. The first such cooperative study is now beginning to address diagnostic, pharmacotherapy and neuroendocrine issues in dementia of the Alzheimer's type, a disease which causes severe disability in tens of thousands of aging veterans. Only the VA has the clinical resources and patient populations which are vital to the success of such efforts. These research efforts together with GRECC clinical and educational programs are already improving the health care of the aging veteran and promise to do even more in the future.

RESPONSE OF DR. MURRAY A. RASKIND, DIRECTOR, SEATTLE/AMERICAN LAKE GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTER (GRECC), VETERANS' ADMINISTRATION MEDICAL CENTER, SEATTLE, WASH., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

Please comment on the quality of leadership that the VA Central Office provides the Seattle/American Lake GRECC? Do you believe it is effective and adequate direction for your efforts? Are the goals you have set for your GRECC consistent with the goals that the Central Office has set for the entire GRECC program?

Answer 1.

The quality of leadership that VA Central Office through the Office of Geriatrics and Extended Care has provided to the Seattle/American Lake GRECC has been of high quality. The recent leadership from the Office of Geriatrics and Extended Care under the direction of Dr. Paul Haber as Assistant Chief Medical Director and Dr. Jule Moravec and Ms. Sue Brennan has been the most effective leadership since my association with the GRECC program began in 1976.

The goals which the Department of Medicine and Surgery in Central Office have had for the GRECCs have been to focus attention on the aging veteran population, to increase basic knowledge of aging and geriatrics, and to transmit this knowledge to health care providers and thereby to improve the quality of care of the aged. The goals of the Seattle/American Lake GRECC have been consistent with these overall goals promulgated by VA Central Office. This GRECC has created a center of research, educational and clinical excellence in which health professionals can become skillful and enthusiastic geriatric practitioners and can develop expertise in academic geriatrics and gerontology. The research goals of the Seattle/American Lake GRECC have focused upon age-related changes in behavior and neuroendocrine function and in the interrelationships between these two aspects of aging. The clinical goals of the GRECC have been to provide model geriatric care units which serve as academic training sites for geriatric health care professionals, prototypes for the VA health care delivery system, and settings for clinical research in geriatrics and gerontology. The educational goals of the GRECC have been to provide VA health professionals at the local, district, and national levels with high quality training in geriatrics and gerontology; to provide geriatric and gerontologic training to University of Washington health care students, and to train health care professionals in the community actively providing care for the aging veterans who are not within the VA health care system itself. All of these goals have been successfully addressed.

Question 2.

Are the present Seattle GRECC staffing and funding levels sufficient for its ongoing and planned projects?

Answer 2.

The Seattle/American Lake GRECC is the only GRECC which is located at two separate VA Medical Centers. Despite having duplicate responsibilities at each medical center, this GRECC is funded similarly to GRECCs located at only one VA Medical Center. Even if all of this GRECC's staffing and funding resources were concentrated at a single VA Medical Center additional resources would still be necessary to implement fully ongoing and planned projects. For instance, the development of a multidisciplinary geriatric care team with the ability to provide outreach evaluation and treatment to elderly veterans living in community nursing homes and other veteran's facilities such as domiciliaries and state soldier's homes has been severely limited by the absence of a GRECC social worker and a GRECC clinical psychologist. In addition, nursing support for this multidisciplinary team as well as for the other GRECC clinical programs is clearly not sufficient. The GRECC research program which is focusing upon behavioral disorders and neuroendocrine disorders in the elderly suffers from the absence of an experimental psychologist, a research neurologist, and a scientist trained in cell biology techniques. Within the constraints of present staffing and funding levels, I believe the Seattle/American Lake GRECC has accomplished a great deal in its diverse mission areas. However, these multiple missions in research, education and clinical care inevitably fragment GRECC resources and detract from achieving the full potential of the program. Additional staffing and funding would correct this problem.

Question 3.

To what extent does the Seattle/American Lake GRECC coordinate and share information with the other 7 VA GRECCs? Is the level of sharing adequate? Should it be increased? To what extent does cooperation and information sharing take place with private sector research on aging efforts?

Answer 3.

The Seattle/American Lake GRECC publishes the quarterly GRECC newletter, Forum on Aging, which is an important information sharing mechanism for both the GRECC program and for the entire VA medical system. The Seattle/American Lake GRECC is also working to develop a collaborative study in the psychopharmacology of Alzheimer's disease which will involve at least 3 additional GRECCs. In addition, information is shared with the other 7 GRECCs at the annual GRECC Director's meeting held in conjunction with the Gerontological Society Annual Meeting and at the annual GRECC Director's scientific meeting held each spring at one of the GRECC host sites. Despite the current level of information coordination and sharing, efforts in these areas could clearly be increased with great benefit to all of the GRECCs. A major problem is the limitation of support for travel by GRECC basic and clinical investigators and GRECC clinicians. GRECC investigators should all attend the annual Gerontological Society meetings, the major annual forumfor gerontological research in this country. Unfortunately, available funds have been insufficient to support this critical item. In addition, support is necessary to enable GRECC clinicians and clinical investigators to meet at the annual American Geriatric Society meetings. Such face-to-face interchange among GRECC investigators and clinicians is the best way to foster consistent and ongoing collaboration and information sharing between the GRECCs.

Cooperation and information sharing with non-VA governmental and private research agencies, such as the National Institute of Aging and the National Institutes of Mental Health take place within regular forums such as the

Gerontological Society meetings, the Endocrine Society meetings, the American Psychiatric Association meetings and other recognized national research and clinical forums. Again, however, information sharing is limited by the scarcity of funds to support travel of GRECC personnel to these forums.

It should be emphasized that despite these limitations the Seattle/American Lake GRECC has been active and visible at national scientific meetings, and published thirty research and clinical papers and chapters in national scientific and medical journals in FY '81, thus making information generated by the GRECCs available on a national and international basis.

Question 4.

Since the GRECC centers have been at VA Medical Centers affiliated with medical schools, to what degree can we expect to see improvement in geriatric health care that VA patients are receiving in the principal places one finds elderly patients; i.e. nursing homes, domiciliaries, extended care beds in VA hospitals, many of which are in facilities unaffiliated with medical schools?

Answer 4.

I can only speak for the Seattle/American Lake GRECC in this regard, although I am confident that the efforts among other GRECCs in disseminating knowledge and improving care in non-medical school affiliated geriatric health care centers has been substantial. It should be recognized that the American Lake VA Medical Center, a component of the Seattle/American Lake GRECC was in fact a non-medical school affiliated facility until 1981 and continues to provide long term care to hundreds of elderly veterans. At the American Lake facility, the long-term care units have directly benefited from GRECC educational and clinical programs. A 20 bed long-term care unit devoted to veterans with Alzheimer's disease has been a major clinical resource which the GRECC established at the American Lake GRECC. In addition, GRECC clinical investigators provide direct clinical care to long-term care wards at American Lake. In addition, the GRECC has made a major outreach educational effort to the other VA Medical Centers in the district (Washington, Idaho, Oregon and Alaska) and to both of the state Soldier's Homes in the state of Washington. Seattle/American Lake GRECC educational teams have presented teaching seminars and clinical consultation rounds at each of the non-affiliated VA Medical Centers in the District (Roseburg, Spokane, Walla Walla) during the past year. In addition, regular monthly teaching and consultation rounds are carried out at each of the two state Soldier's Homes, neither of which is affiliated with a medical school. It should be emphasized that most elderly veterans receive long term care in community-based facilities outside of the VAMCs. To address the needs of these veterans, GRECC faculty have delivered more than forty local and national continuing medical education seminars and lectures in FY '81 to over 2,000 physicians and other health care professionals involved in community long term care of elderly veterans.

Question 5.

Has the quality of care rendered to veterans in geriatric centers or other affiliated VA Medical Centers been changed as the results of the GRECC program?

Answer 5.

Again, I think it most appropriate that I respond to this question concerning the Seattle/American Lake GRECC and the two VA Medical Centers of which the GRECC is a part. The quality of care rendered to elderly veterans both at the Seattle VAMC and the American Lake VAMC has improved since the advent of the GRECC. At the American Lake VA Medical Center, the establishment of a unit for evaluation and treatment of Alzheimer's disease has answered an important need for specialized services for elderly veterans suffering from this devastating disorder. In this unit, elderly veterans suffering from Alzheimer's disease receive expert care from a highly motivated and skilled staff in an environment designed to mimimize psychotropic medications and maximize function. Multidisciplinary geriatric outpatient clinics at both the Seattle and American Lake VA Medical Centers are providing multidisciplinary evaluation and longitudinal treatment for elderly veterans with complex medical, behavioral and social problems. Many of these veterans who previously were not followed in a longitudinal manner are now receiving high quality comprehensive care. The multidisciplinary geriatric inpatient consultation team is providing an important service to elderly patients with complex problems. Again, patients seen by the team are placed into a longitudinal geriatric health management system which optimizes continuity, and should reduce the need for repetitive inpatient admissions. The geropsychiatry evaluation and treatment unit at the Seattle VA Medical Center provides expert care to elderly veterans with acute behavioral disorders. This unit has centralized expertise and has developed innovative treatment techniques for the elderly psychiatric patient. Similar innovative clinical units have directly improved the quality of care at other GRECC sites throughout the country. It should be added that GRECC educational efforts are improving the quality of care to elderly veterans far beyond the limited capacity of the GRECC clinical units themselves.

Question 6.

How much direct care is currently provided by the Seattle/American Lake GRECC at the VA Medical Centers there? (Although this question was initially addressed to clinical care at the Seattle GRECC only, I feel the committee probably wants to know about the clinical care at the entire GRECC which encompasses clinical programs at both medical centers).

Answer 6.

The clinical responsibilities of the GRECCs are to supplement the basic core staffing provided by the host medical center for clinical units relevant to the research and educational mission of the GRECCs. Obviously, the Seattle/American Lake GRECC with a total FTE allocation of 16 would be unable to provide core staffing for even 1 inpatient unit even if all GRECC FTE were dedicated to that single clinical task. Thus, the GRECC can only supplement inpatient unit core staffing at both VAMCs with GRECC physician, nursing and other personnel. The outpatient and consultation units are primarily staffed by GRECC personnel. At the Seattle VA Medical Center the GRECC geropsychiatry inpatient unit has 12 operating beds and treated 108 inpatients during FY '81. The GRECC multidisciplinary outpatient clinic had 839 visits in FY '81 and the GRECC multidisciplinary consultation team evaluated 307 patients in FY '81. The American Lake VA Medical Center

GRECC Alzheimer's Disease Inpatient Unit has 18 operating beds which treated 22 long term patients.

Question 7.

How are the Seattle GRECC funds allocated between its research, education and clinical activities?

Answer 7.

Approximately 50% of GRECC funds are allocated towards the GRECC research effort, 20% towards GRECC educational efforts, 20% to clinical efforts and 10% to administrative endeavors.

Question 8.

How are staff and support allocated among the 3 areas?

Answer 8.

Each GRECC professional staff person has multiple missions which involve research, education and clinical activities. For instance the GRECC physicians function as clinical investigators in research, direct care providers in the GRECC clinical programs, and educators for fellows, medical students, and other health care professionals. When examined with this proviso in mind, 40% of staff time is allocated to research, 22% to education, 25% to clinical activities and 13% to administrative activities.

Question 9.

To what degree is there coordination and communication between the Seattle GRECC program and the other 7 VA GRECC programs?

Answer 9.

Parts of the answer to this question are contained in the answer to question 3 above. The Seattle/American Lake GRECC program has regular communication with the other GRECC programs at the annual director's meeting, at the annual GRECC research meeting, and at other forums throughout the year at which GRECC directors and other GRECC personnel may gather. In addition, the GRECC newsletter, The Forum on Aging, serves as a useful means of communication, and GRECC Directors regularly communicate informally concerning collaborative scientific issues as well as administrative issues affecting the GRECC program and geriatrics within the Veterans Administration.

Question 10.

How has the Seattle GRECC served as a resource for other educational units of the VA; i.e. Regional Medical Education Centers, Learning Resource Centers, Comprehensive Health Educational Programs?

Answer 10.

The Seattle/American Lake GRECC has had a longstanding collaborative arrangement with our district's InterWest RMEC as well as cooperative efforts with other RMECs throughout the nation. The GRECC serves as a source of expert faculty and content advisors for RMEC programs for geriatrics and gerontology. During FY '81, GRECC staff served as faculty for RMEC programs in Salt Lake City, Utah, in Boise, Idaho, in Seattle, Washington, in Tacoma, Washington, at Long Beach, California and Los Angeles, California. This collaboration includes interaction with the Learning Resource Center, which is incorporated within the InterWest RMEC. The GRECC has also supplied faculty and expert educational content advice to the comprehensive health educational program in Boise, Idaho.

Question 11.

How is your research integrated/coordinated with the National Institute on Aging and other private sector research units?

Answer 11.

GRECC investigators are also investigators for the National Institute on Aging and the National Institute of Mental Health through successful competition for peer reviewed grant support. For instance, the GRECC research effort in the aging autonomic nervous system for which Dr. Jeffrey Halter is the principal investigator, receives substantial grant support from the National Institute on Aging. Similarly, the sleep and diurnal rhythm in Alzheimer's disease project for which Dr. Patricia Prinz is the principal investigator receives substantial grant support from the National Institute of Mental Health. In addition, GRECC investigators regularly participate in research forums sponsored by the National Institute on Aging and serve as experts in geriatrics and gerontology to both the National Institute on Aging and the National Institute of Mental Health.

Question 12.

To what degree have geriatric fellows, and other health professionals who have received training in the Seattle GRECC remained in the VA as clinicians and teachers?

Answer 12.

Unfortunately, the Seattle/American Lake GRECC was not a recipient of a VA Geriatric Fellowship Program. However, the Seattle/American Lake GRECC, in collaboration with the Department of Psychiatry and Behavioral Sciences at the University of Washington, successfully competed for a National Institute of Mental Health training fellowship grant in geriatric psychiatry and geriatric psychology. Of the 3 geriatric psychiatry fellows (physicians) who have completed the fellowship program 2 have remained in the VA as clinicians and teachers. One serves as a full-time geriatric clinician and faculty member at the Seattle VA Medical Center. The second devotes part-time to clinical geriatrics at the Seattle VA Medical Center. Of 3 geriatric psychology fellows (clinical psychologists) 2 have remained as full-time faculty at the University of Washington School of Medicine in geriatrics, although neither is employed by the Veterans Administration. If positions for clinical psychologists had been available, it is highly likely that some if not all of the geriatric psychology fellows would have remained with the Veterans Administration in geriatrics.

Chairman SIMPSON. Now Stanley Brody, professor of physical medicine and rehabilitation in psychiatry, executive administrator for research and training center in aging, University of Pennsylvania in Philadelphia; Dr. Donna Cohen, associate professor of psychiatry and neuroscience, director, division of aging in geriatric psychiatry; and Jack Westall, former Director of the Veterans' Administration Medical Center in Bay Pines, Fla., former Assistant Chief Medical Director for Administration, VA, Washington.

It's good to have you with us this morning and if you would just proceed; and if you could limit your testimony to 5 minutes we may have a bit of time for questioning.

So, please.

Dr. BRODY. Shall I go first, Senator?

Chairman SIMPSON. If you would, Dr. Brody.

TESTIMONY OF A PANEL CONSISTING OF: STANLEY J. BRODY, PROFESSOR OF PHYSICAL MEDICINE AND REHABILITATION IN PSYCHIATRY, EXECUTIVE ADMINISTRATOR FOR RESEARCH AND TRAINING, CENTER ON AGING, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA.; DR. DONNA COHEN, ASSOCIATE PROFESSOR OF PSYCHIATRY AND NEUROSCIENCE, DIRECTOR OF DIVISION ON AGING AND GERIATRIC PSYCHIATRY AT MONTEFIORE MEDICAL CENTER AND ALBERT EINSTEIN COLLEGE OF MEDICINE, DIRECTOR OF RESEARCH AND EVALUATION AT BETH ABRAHAM HOSPITAL OF THE MONTEFIORE MEDICAL CENTER, NEW YORK, N.Y.; AND JACK S. WESTALL, FORMER DIRECTOR OF THE VETERANS' ADMINISTRATION MEDICAL CENTER, BAY PINES, FLA., AND FORMER ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION OF THE VETERANS' ADMINISTRATION, WASHINGTON, D.C.

Dr. BRODY. First, I want to second the comments that were made by my colleagues.

In many years of testifying on the Hill on aging I'm delighted with the knowledge of the subject that was demonstrated this morning by the chairman and Senator Cranston.

Chairman SIMPSON. Well, thank you.

Mr. BRODY. I'd like to make a few quick points rather than go through written testimony.

First, we aren't talking enough about the second demographic revolution in aging which is the aging of the aged.

What we're really seeing is two distinct population revolutions. One, occurred in 1965 and another one which has been happening during the last 10 years. In that time the number of people over 85 increased by 67 percent.

The reason to stress that is that the nature of the aging in part from the resources that are being spent on that particular portion of the elderly population.

For example, approximately 40 percent of the expenditures of medicare for the people 85 and older are spent in dying in a hospital; and this represents a higher per capita medicine expenditure. It's a very important point of information the Congress has to appreciate in making their plans.

The second point, which goes back to the aging of the aged, is the very difficult time we all seem to have in distinguishing between health and medicine. We keep equating health needs of the elderly with medical care and acute care.

This is repeated in the aging veterans' report, which is a first class report, entitled "The Aging Veteran: Present and Future Medical Needs." In the text, however, the medical needs are very modest compared to the larger health/social needs, and the program described focusses on long-term care.

The first issue to be faced is what do you want to do in terms of meeting needs of the aging veteran? To answer that question you have to identify the nature of those needs.

The VA has started a new approach in looking at these health needs in terms of disability rather than disease reflecting the best thinking in gerontology.

This committee—and I speak as a veteran, and within a year I will be an aged veteran—is faced with the problem of how to allocate resources between acute care and long-term care; between a disease focussed approach as distinguished from one placing an emphasis on preventing, modifying, and ameliorating disabilities.

The nature of the resources that the VA has in acute care are uneven at best; and that's a generous statement.

On the other hand, in long-term care there is no single agency in the United States and perhaps in the world that has the system operative in the VA long-term care system.

It's all in place. As part of my written testimony I've submitted an ideal long-term care system. If you ran your eye down through the services of that system you would see that the VA at one point or another, at some place, has that service in place.

I would suggest, too, that we review Senator Cranston's original idea of 10 years ago; that one of the ways of resolving of resource allocation between acute care and long-term care is by thinking through again the possibility of the VA buying into medicare. Thirty percent, by the VA's own figures, of acute care is currently provided pensioneers. Well, if you follow the "buy-in" idea it suggests to you that SSI, which is a pension system, uses buy-in of medicare for that population. It follows, I think, that one should look very seriously at the possibility of the VA paralleling the States' efforts for their pensioneers.

I might make one point in addressing myself to a question, Mr. Chairman, that you asked a little earlier about why the larger use of institutionalization of veterans in long-term care.

To a large extent, the veterans using the VA service system represent a population with fewer social resources. Furthermore the true alternative to institutionalization—as research repeatedly has demonstrated—is daughters and daughters-in-law.

If you don't have an available daughter or daughter-in-law, the likelihood of your being institutionalized goes up significantly.

In addressing a VA population, particularly a male VA population, one has to appreciate that that population, at least in the past, has had less social resources in terms of daughters and daughters-in-law.

The last point I would make is only to affirm, really, what Dr. Haber has spoken to in response to your question.

I would hope that we see the older person as somebody who can be rehabilitated and that the rehabilitative goals for the elderly are seen not in terms of a younger generation. Rather the goals are returning to the community because the older veteran has learned again how to transfer from bed to a chair, to walk to the toilet, to do the small tasks of self-care; these kinds of modest rehabilitation goals.

The VA has been the single Federal agency other than the Rehabilitation Service Agency that's taken major initiative in rehabilitation.

Initially, of course, that was in terms of a younger population.

Now we're dealing with an older population and rehabilitation is just as effective and just as important if not more so. Almost all the amputees in this country are old people. We have to continue to emphasize a positive therapeutic approach toward them and all of the elderly be they veterans or not.

Chairman SIMPSON. I must ask you to conclude.

Thank you very much.

[The prepared statement of Stanley J. Brody, professor of physical medicine and rehabilitation in psychiatry, executive administrator for research and training, Center on Aging, University of Pennsylvania, Philadelphia, Pa., and his response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF STANLEY J. BRODY, J.D., M.S.W., PROFESSOR OF PHYSICAL MEDICINE AND REHABILITATION IN PSYCHIATRY, EXECUTIVE ADMINISTRATOR FOR RESEARCH AND TRAINING, CENTER ON AGING, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA.

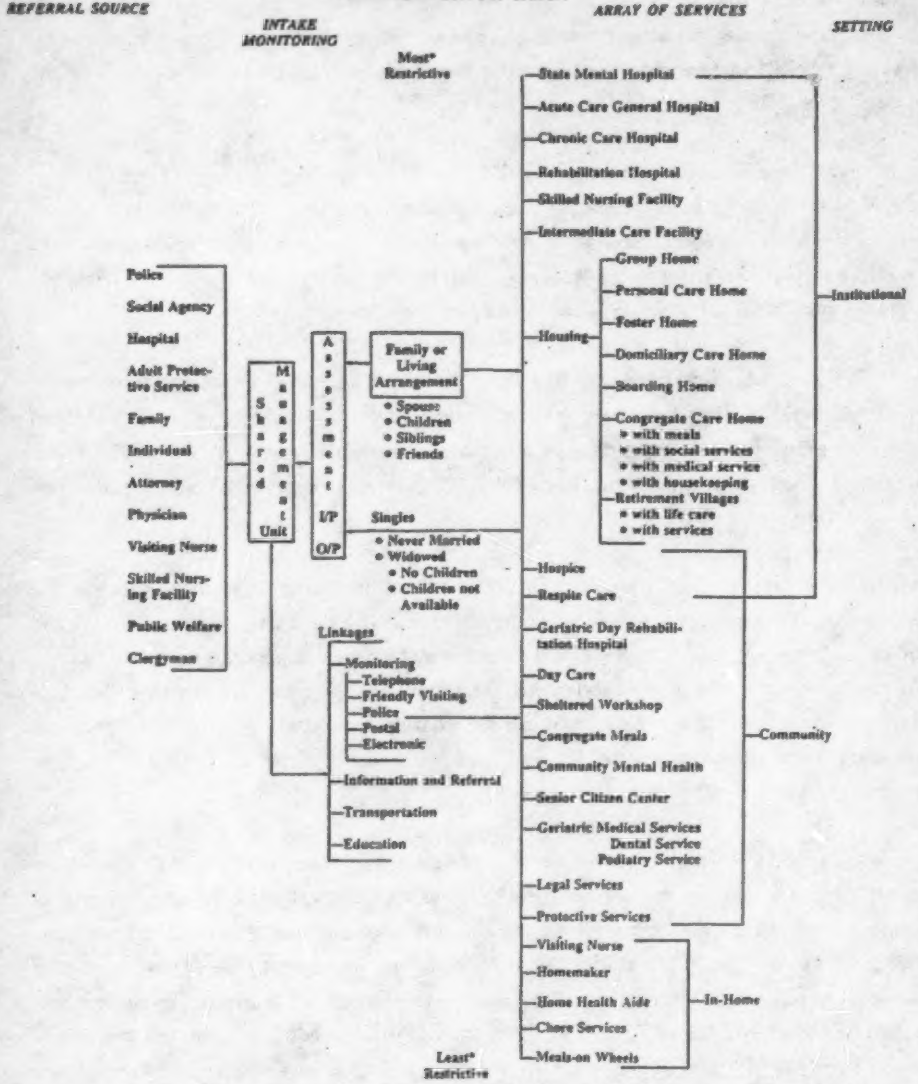
My name is Stanley J. Brody. I am Professor of Physical Medicine and Rehabilitation in Psychiatry of the Medical Center and Executive Administrator of the Rehabilitation Research and Training Center in Aging at the University of Pennsylvania. I have a long standing interest in aging, long term care and rehabilitation, and therefore appreciate this invitation to discuss these subjects as they relate to the Veteran Administration.

The health problems of the aged with which this country is struggling are even more significant to the Veterans Administration. Within the next decade the number of aged veterans will peak to include almost two-thirds of all males over 65 years of age. This demographic imperative has led this Committee to require the V.A. to review its program (P.L. 94-584). The respondent report, entitled The Aging Veteran: Present and Future Medical Needs (October 1977), was a landmark effort.

The major issue to be resolved in preparing programmatic responses to the problems of health care of all of the aged concerns the definition of health needs. Specifically -- are those health needs acute (temporarily) or are they chronic (long term)? The same issue is facing this Committee in focussing on the aged veteran. The repetitive equating of health care with medical care is the basis of the confusion surrounding this issue. Thus the title of the key report, "Aging Veteran" is couched in terms of medical needs. The report itself, however, concerns itself at length with the array of services that make up a long term care (LTC) system. "Medical needs" and "medical services" are an important part of the LTC system, but as the "Aging Veteran" report recognizes, there is a greater significance of health/social services in the continuum of care (c.f. attached chart).

What emerged in the Aging Veteran report was a projection of the measure of chronic illness that the older veteran will experience. In an important departure from the way in which this problem has been approached by other governmental agencies, the V.A. described patient care needs in terms of levels of disability rather than in terms of

LONG-TERM SUPPORT SYSTEM


REFERRAL SOURCE
INTAKE MONITORING
ARRAY OF SERVICES
SETTING
Most* Restrictive
State Mental Hospital
Acute Care General Hospital
Chronic Care Hospital
Rehabilitation Hospital
Skilled Nursing Facility
Intermediate Care Facility
Housing
Group Home
Personal Care Home
Foster Home
Domiciliary Care Home
Boarding Home
Congregate Care Home
• with meals
• with social services
• with medical service
• with housekeeping
Retirement Villages
• with life care
• with services
Institutional
Police
Social Agency
Hospital
Adult Protective Service
Family
Individual
Attorney
Physician
Visiting Nurse
Skilled Nursing Facility
Public Welfare
Clergyman
Shared Management Unit
Assessment
I/P
O/P
Family or Living Arrangement
• Spouse
• Children
• Siblings
• Friends
Singles
• Never Married
• Widowed
• No Children
• Children not Available
Hospice
Respite Care
Geriatric Day Rehabilitation Hospital
Day Care
Sheltered Workshop
Congregate Meals
Community Mental Health
Senior Citizen Center
Geriatric Medical Services
Dental Service
Podiatry Service
Legal Services
Protective Services
Community
Linkages
Monitoring
Telephone
Friendly Visiting
Police
Postal
Electronic
Information and Referral
Transportation
Education
Visiting Nurse
Homemaker
Home Health Aide
Chore Services
Meals-on Wheels
In-Home
Least* Restrictive

Inventory of Recommended Available Services, Appropriate to a Long-Term Care/Support System

* The classification of from most to least restrictive is a general view of services and may vary within each service.

Source: Brody, S.J. and Masciocchi, C. "Data for Long-Term Care Planning by Health Systems Agencies", AJPH, 1980, 70(11), 1194-1198.

disease or mortality. This classification of need, while subject to critical modification, was the first such effort by any public agency (c.f. Figure B-3, Aging Veteran, p. 15). It was an acknowledgement of the pervasiveness of chronic illness in the elderly and the resulting disability.

Given the enormity of the need for LTC by aging veterans, the medical emphasis of the V.A. on medical needs and acute care should be reviewed. During the last fifteen years, the aged in general have been provided with an adequate catastrophic acute-care medical support system through Medicare. During the same period of time, an adequate parallel system for LTC has not been developed.

The V.A. acute-care system has been described by some as being of moderate quality. The V.A. long term care system, while still short of adequacy, is, nevertheless, the best existing effort towards developing a LTC system. The array of services (c.f. attached chart) which make up a model LTC system is currently present under one administrative roof in the V.A.

It is suggested that the question facing this Committee is how to allocate the limited health resources for aged veterans between acute care and long term care. The acute care system for all of the elderly, funded by Medicare is generally accepted as one of the best in the world. The existing LTC system for the aged, on the other hand, is seriously deficient. If the V.A. could use the existing community acute care system that is available to all older people for the aged veteran, it would free its resources to improve the already good V.A. LTC system.

One way in which this could be accomplished would be for the V.A. to purchase coverage and to pay the co-pay for the elderly or disabled veterans for whom they now provide direct acute medical services. One option to accomplish this would be to follow the procedure of "buying in" to the Medicare system. Since most elderly have Medicare eligibility, this would require enrolling aged veterans in Part B by paying the current monthly enrollment fee of Part B of Title XVIII (SSA). In addition, the deductible and co-pay for hospital stays under Part A, and the deductible and co-pay ambulatory care under Part B would be part of the V.A.'s responsibility. For those few not covered by Medicare, there are special buy-in provisions for Part A coverage.

An initial step in instituting such a program would be to buy-in for recipients of V.A. pensions. This group uses almost 30% of the bed days in acute-care V.A. hospitals. A similar approach has been used by many states in providing for recipients of SSI. The net effect has been high quality acute care at a relatively reasonable and pre-determined cost. The resultant savings could then be applied to expanding the V.A. LTC System.

Another option could be to follow the Department of Defense method of CHAMPUS which, in effect, indemnifies dependents of members of the armed services for medical expenses. This is more costly than Medicare, however because the effect of the indemnification procedures, is that the system would be paying for hospital charges rather than the lower negotiated Medicare rate.

There are at least three groups who may object to diminishing the role of the V.A. in the direct provision of acute services. First, some members of the medical staff -- like similar staff in acute care facilities in general -- have little interest and no formal background in addressing LTC issues. The IOM report on medical education* and the Senate Committee on Aging's report on physicians in nursing homes** are definitive statements of the traditional medical view towards participation either in training or service in LTC. The shift from acute medical care to LTC may be viewed by some physicians as a lessening of their role.

Second, many medical schools may not support a reduction in the emphasis on the direct provision of acute care. To be sure there could be expanded opportunities for medical education within long term care settings and some medical schools may respond to such new possibilities. This is consonant with the objective of the National Institute of Aging to have medical schools train their students in skilled nursing facilities.

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* Institute of Medicine: "Aging and Medical Education", Washington, D.C. National Academy of Science, 1978.

** "Doctors in Nursing Homes: The Shunned Responsibility". Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper No. 3, Sub-Committee on Long Term Care, February 1974, 94th Congress, 1st Session.

Similarly, the GRECC effort could be addressed to focus on the physician's role in the LTC system. It is more likely however, that a diminution of direct acute hospital care by the V.A. would probably be received negatively by the more than 100 medical schools using those facilities for training purposes.

Finally, the aged veteran himself, like other older people, may not appreciate the importance of expanding the V.A. LTC system. Invariably when LTC is needed, the family member of the elderly person remarks "I never thought we'd come to this". To a large extent this understandable myopia has limited the development of LTC in this country. The promise of more available high--quality acute care might encourage the aged veteran and his constituency to support the V.A. in a shift in emphasis to LTC.

Within the V.A. LTC system itself, major importance should be given to rehabilitation services for the elderly disabled. The V.A. pioneered the use of rehabilitation medicine under the impetus of World Wars I and II. The target population then was a young population disabled by the traumas of battle. The disabled population today is elderly and chronically ill.

The incidence of chronic illness (80%) and the resultant disability is much higher in older persons than in any other age group. National studies of the functioning of the elderly indicate that mobility and activity are the primary indicators of disability. Of the 20% of the aged who suffer significant limited mobility, 2% are bedfast, 5% housebound, 7% can move about with assistance and 5% move around with difficulty. In terms of the overall proportion of older people who are limited in their activities, more than half are free of functional limitations. The remaining 45% are limited in their function; about 17% are unable to carry out their major activity. This compares with people of all ages of whom only 14% are limited and 3% are unable to carry on their major activity. It is estimated that as many as 30% of the elderly in the United States are in need of assistance because of disability.

Moreover, as the aged veteran group moves toward advanced old age, it will become more vulnerable to dependency. While 20% of all aged will be in a nursing home at sometime, those over eighty have a 50% chance of being institutionalized. Not only are the old-old prone to more physical and mental impairment, but they are also subject to more losses of social and economic supports.

Most disability comes from the most common afflictions of arthritis and cardiac diseases. Less familiar is the fact that 85% of all amputations in the United States during peace time are the result of complication of arteriosclerosis obliterans and diabetes mellitus in the elderly. Until recently many elderly persons were rejected for prosthetic fitting and training "because they were too old to learn how to handle a prosthesis."

Moreover, hemiplegics compose the majority of geriatric patients who need long-term rehabilitation. At least 90% of elderly hemiplegics have rehabilitation potential; however, this potential diminishes if bedrest is prolonged and an effective rehabilitation program is not started almost at once. Over 80% of elderly hemiplegics were found to have rehabilitation potential several weeks after a stroke, and over 50% were able to return to their own homes.

Within the V.A. LTC system, the rehabilitation service has two main functions. Primarily it is the key service to maximize the level of self-care for the disabled elderly. It is through this kind of effort that the elderly are more likely to remain in the community, which is their preference. For those not too severly impaired, this represents a potential cost saving over institutionalization. Secondly, the rehabilitation service has been assessing personal and environmental resources since its inception. This assessment procedure is a vital part of any LTC system and critical to the case management approach on which the LTC system is built.

In summary, it is suggested that the V.A. should respond to the aging of its target population by reallocating its resources from acute care to LTC; that it should initiate this move by purchasing acute care coverage for its pensioners through Medicare; and that in enriching its existing LTC program a major effort be made to expand rehabilitation services for the disabled elderly veteran. This approach would maximize the use of V.A. resources and provide both the acute care and long term care needed by the growing aging veteran population.

RESPONSE OF STANLEY J. BRODY, PROFESSOR OF PHYSICAL MEDICINE AND REHABILITATION IN PSYCHIATRY, EXECUTIVE ADMINISTRATOR FOR RESEARCH AND TRAINING, CENTER ON AGING, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. Compare the VA's current policies, concerning the care and treatment of aging veterans, with the private sector's current policies, concerning the care and treatment of the general aging population.

Answer 1. Within a single system, the VA has all of the services which comprise an ideal long term care system. They either deliver these services directly or they purchase them from other community agencies. There is no comparable arrangement in the private sector, including the few long term care demonstration projects which have been mounted by HCFA and AoA.

However, the VA has built-in eligibility limitations that hamper its capacity to provide continuity of care over an extended period. For example, there is a time limitation on the purchase of skilled nursing care from community resources.

Question 2. In your capacity as a specialist on aging, what combination of needs do you anticipate this aging veteran population will have, and what array of health and social support services should the VA provide in order to best provide care for that population?

Answer 2. The array of services presented to the Committee as part of my written testimony represents what an ideal medical, health and social support system would provide. The new aging veteran population will be different from the group that has been served by the VA in the past. Virtually all of them will have Medicare coverage for catastrophic acute medical care. They also will have more extensive social support systems, and they will live to much older ages. Accordingly, their needs will be for continuity of care for the disabilities which are most likely to occur in old age, i.e., over 75 years, and for encouragement of their informal support systems.

Question 3. Do you believe that such an array of services exists now within the VA health-care system?

Answer 3. Such a long term care system exists piece-meal within the VA today. It needs rationalization, filling-in and structure. The last would provide a management system that would assure needs assessment and continuity of care. There are a few gaps in service such as respite care and protective services. These might be purchased from community agencies.

Question 4. Would you change or re-direct the VA's program that treats its aging veterans? If so, how?

Answer 4. I would recommend moving the VA out of the direct acute care business. There is an adequate acute care system already extant and the VA is duplicative at best. The Canadians came to that conclusion and gave all of their acute hospital resources to local communities.

The VA program should be redirected and expanded to provide long term care including rehabilitation. This would provide the assistance needed, both by young and old veterans, that is not available in the larger community.

Question 5. What barriers do you believe exist in the VA health-care system which may prevent the "de-institutionalization" of its aging population?

Answer 5. "De-institutionalization" is not a realistic goal. At one point or another, we all may need institutional care. The goal should be to provide a balanced array of services which makes available the "right service at the right time." A rational management system which does not currently exist, might assure appropriateness of service. The VA "aid and assistance" program to families to encourage their care of disabled old veteran family menbers will be increasingly useful in the future to prevent or postpone unnecessary use of institutions. Respite care is another family-focussed service that would have the same result. As the aged veteran's family resources change in the next two decades, the VA should be prepared to respond to new situations by providing extensive family-focussed support. Where there is no informal support available, surrogate family care might be provided through congregate housing facilities with built-in services, foster care or other small group living arrangements.

Question 6. Are community-based programs, which provide health and social support services to the elderly, available throughout the Nation?

Question 7. Are these programs standard? Do they vary in quality and quantity?

Answers 6 & 7. In each community there are some elements of a health and social support system in place. They are unequal, and in many situations, some services are not available. Furthermore, they are encrusted with complex eligibility, administrative, funding and benefit limitations which hamper their accessibility and availability.

Question 8. Would you comment on the effectiveness of the present role of the VA GRECCs in the agency's overall program of providing health care to eligible veterans? Please address each of the three program areas of geriatric care, i.e., research, education, and clinical activities.

Answer 8. The VA GRECCs are uneven in performance. A major problem is the lack of enthusiasm of medical education for relating to the health as well as the medical problems of the aged. To be effective, GRECCs must require a clear commitment of the medical school to an interdisciplinary approach to health care of the aged and a recognition for the legitimacy of the physician role in long term care demonstrated and articulated in undergraduate curricula. However, the provision of GRECCs has helped some medical schools to focus somewhat in this direction. There is no question that a research and education program focussed on the elderly does improve the clinical care of the aged veteran, even it it is limited to acute care. Currently the GRECC performance is uneven, depending to a large degree on the perception of the host medical school of the "health care" of the elderly, rather than a limited acute medical care approach.

Question 9. Please explain how the VA health-care system "fits" into the geriatric care model that you submitted to the Committee with your written hearing testimony.

Answer 9. A review of the array of services presented in the geriatric Care model submitted demonstrates that the VA provides virtually every service unit in some facility. What is missing is the rationalization of these services into an organizational design. The first step to achieving such a system is a commitment to the goal of providing services needed to help the aged veteran and his family achieve the highest level of self-care possible.

Chairman SIMPSON. Dr. Cohen, please.

Dr. COHEN. Yes. I want to thank you on three counts today.

One is caring enough about the problem of the aged veterans to ask such penetrating questions of your first panel and for highlighting Alzheimer's disease, which is probably the silent epidemic of the next century.

Second, to compliment you on pronouncing it correctly and our not having to spell it for you.

The last time I was in Congress I had to spell it repeatedly for honorable Congressmen.

Third, I want to thank you for——

Chairman SIMPSON. They have that trouble over there. [Laughter.]

Dr. COHEN. I'm seeing some of them, yes.

Third, to thank you for making me feel older and wiser.

Just some bit of history, Dr. Busse was one of the people who I think was instrumental in starting aging off as a national focus and an international focus, and I was fortunate enough to be at Duke when he started the ventures there.

I now come to you from New York to present to you two different messages.

One is that New York, having 1 out of every 20 older Americans has begun, I think, some very innovative and integrated health care programs for the aged. New York State initiated cost cutting procedures in 1974 and has been ahead of the Nation, I think, in promoting cost effective, cost beneficial and quality care for its aged.

I also come from the Montefiore Medical Center which, in 1947, initiated the very first home care program in the United States which became the prototype for many hospital based departments. It was an integral part of patient care and was used as a basis for the provisions of the original medicare law. Montefiore has over 40 geriatric programs which several colleagues and myself are in charge of developing.

Health care is undergoing a series of changes of such magnitude that as we've heard today even defining its parameters in the VA is difficult. However, any change should have its goal, programs that ultimately improve people's health and promote cost effectiveness without compromising care.

We also need to develop reliable social indicators so that we can determine whether the changes and the reforms that we are implementing are actually meeting our goals.

Health care of the aged is a particularly difficult problem, and it's facing a number of significant barriers, and the barriers are very simple. They're the barriers of tradition.

Dr. Raskind and Dr. Brody and Dr. Busse all alluded to some of these points. As Dr. Raskind said, we have a very limited medical orientation to the medical care of older people. Second, our health delivery system in the VA fosters a dependency on both our acute care and our long-term care institutions. Third, and all of the speakers have highlighted this, we really are lacking the research data to develop the health care programs which will deliver the highest quality care.

There is little emphasis in the VA, except in a few centers, on supporting the families who are the primary care givers. Elaine Brody's data show that 60 to 80 percent of the care delivered to older Americans is by their social support system.

I think the most important message I want to leave with the committee and the observers today is that, we must examine carefully our model of care for older adults and older veterans. Much of our discussion today has focused upon older Americans and older veterans as if they're charity cases, people that we're worrying about. I submit that our health-care system must begin tc regard older veterans as resources for this country. Our health care programs must begin to develop their functional effectiveness, not just their health status. We must invest in making them viable older Americans who continue and can continue to be contributors to this country and our society.

I have enclosed in my testimony a copy of Dr. Brody's array of long-term care services because the Montefiore and Einstein system has, just as the VA, each one of these programs, from institutional care sites, psychiatric hospitals acute care sites, the chronic disease hospital, through home care settings and community based settings. I have in my testimony and will be happy to supply additional information on how we succeeded in creating an integrated model of continuous health care for the aged.

The chronic care management model, which is also called case management as well as channeling, has been funded by the Administration on Aging in 10 sites across the country to look at whether we can package health care for older adults. The Johnson Foundation has funded us at Montefiore to develop the management tools to identify whether we're really developing the programs that are needed and supplying the services that are needed.

I think the VA has long recognized their need to provide acute medical care to the aged and the disabled veteran, and is now coming to terms with the need to provide long-term care. I think it's important that the VA go one step farther—to examine the complex relationship which exists between acute-care and long-term care.

The acute-care hospital should not be abandoned. In fact, it should be changed and innovative programs added. I know some of this has occurred at the Seattle VA, but I think we should look at developing staging areas or rehabilitation areas where specialized interdisciplinary team activity can take place to actively rehabilitate older people and facilitate discharge planning. I have identified in my testimony key research policy questions which the VA must answer.

I conclude with the plea which is that the VA examine its model, its philosophy and its attitude toward the older veteran, to invest in them as people not just as patients, and I assert that we clearly need a program of community oriented long-term disease management. To ignore the impact of the larger veteran population I think is to risk a serious crisis.

I end by announcing that I'm also a member of the Medical and Scientific Advisory Board of the ADRDA, the Alzheimer's Disease and Related Disorders Association, and met with Mr. Stone and that group in the annual meeting last week in Chicago. ADRDA is over 50 chapters strong and feels strongly about the specialized needs of the Alzheimer patient who is 50 percent of the institutionalized population and probably 10 to 20 percent of the population of the United States at large.

Thank you.

Chairman SIMPSON. Thank you very much, Dr. Cohen.

[The prepared statement of Dr. Donna Cohen, associate professor of psychiatry and neurosciences; head, division of aging and geriatric psychiatry, Montefiore Medical Center and Albert Einstein College of Medicine, Bronx, N.Y., and her response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF DR. DONNA COHEN, ASSOCIATE PROFESSOR OF PSYCHIATRY AND NEUROSCIENCES; HEAD, DIVISION OF AGING AND GERIATRIC PSYCHIATRY, MONTEFIORE MEDICAL CENTER AND ALBERT EINSTEIN COLLEGE OF MEDICINE, BRONX, N.Y.

I am honored to be invited to testify before this distinguished Committee on Veterans' Affairs to discuss a serious challenge for our nation--long-term health care of our aging population. I will describe the continuum of geriatric health care programs Montefiore Medical Center has implemented as well as make specific recommendations to this committee for long-term health care planning.

To meet the increasing need for the health care of our aging population, more financial resources will be required, either to develop more nursing home services or to implement a different array and mix of health services, both formal and informal. Our current strategies of long-term care treatment are expensive and insufficient, and new alternatives must be explored (Eisdorfer, 1981). Nursing home expenditures alone amounted to 17.8 billion dollars in 1979 and are projected by HCFA to be over 75 billion dollars in 1990.

The failure to implement a national policy of alternatives to nursing homes or of alternatives within the institution has created new burdens. The result is an inadvertant policy of no care, poor care, or institutional care rather than an approach which increases the health and functional effectiveness of older persons, including their ability to make contributions to society. The history of long-term care health planning and the current state of practice have been thoroughly reviewed in a discussion paper by HCFA (1981) and Brody & Spivak (1982). The challenge to the Veteran's Administration is to develop policies and programs to care for its aging constituency at risk for institutionalization.

Approximately 4.5% of the aged are in nursing homes, but most health care service for older persons are given in general hospitals and outpatient settings. There are 5,840 non-federal acute care general hospitals (American Hospital Association, 1980) and 144 Veteran Administration's hospitals (V.A., 1977). Brody (1980) reported that in 1979, about 5 million persons aged 65 years and older were hospitalized for a total of 10 million admissions, 38.8 percent of in-patient days; 25% of older Americans used out-patient facilities for a total of 10 million visits.

The aging and aged clearly utilize a significant portion of the formal health services. A concerted planning effort is needed to care for our aging population. There are solutions to our long-term health care problems, and a wide array of long-term care health services can be implemented to reduce dependency upon institutional care in both short and long-term care settings. The Montefiore Medical Center and Albert Einstein College of Medicine currently have more than forty geriatric health care programs. One of our major goals is to create a model system of health care for older persons, since we have the full range of services conceptualized by Brody (1980) in Fig. 1. In 1947, Montefiore initiated organized home care as a regular patient service in an effort to deal with the aging chronically ill population in the Bronx.

It became the prototype for similar departments in hospitals across the country and the basis for home care provisions in Medicare.

THE BRONX

The aged in the Bronx and Westchester use a substantial proportion of health and long-term care services. Although the number of older persons living in the Bronx declined from 1970-1980, (from 173,423 to 151,298), the proportion of aged 65 and older increased from 11.8% to 13.2%. Thirty-one percent live alone. By 1984/85, it is estimated that 50% of the aged population in the Bronx will be age 75 and older, significantly higher than the national average. Furthermore, there are more than 18,000 persons age 85 and older in the Bronx.

There are 10,850 long-term care beds in the Bronx, representing the largest number of beds for any of the city's five boroughs. Bronx residents use long-term care facilities at a rate higher than residents of any other borough, and 70.3% of Bronx long-term care beds are filled with Bronx residents. Bronx long-term care institutions have been operating at consistently high occupancy rates like all institutions in New York City, but Bronx facilities have more Medicaid, fewer Medicare and less reserve patient days than facilities in other boroughs.

THE MONTEFIORE - EINSTEIN MEDICAL COMPLEX

The Montefiore Medical complex is among the most comprehensive and diverse regionalized voluntary health care systems in the country. In the scope of its clinical activities and budget, it is among the largest private non-profit medical centers in the U.S. The Montefiore Medical Center includes four major hospitals, a chronic disease hospital, a number of free standing ambulatory health centers, a model prison health service, a medical group and HMO, home care programs and several long-term care facilities. In addition, relationships exist with a range of other private and public facilities, including a state psychiatric hospital, for educational, clinical or social services purposes. The complex, which includes the Hospital of the Albert Einstein College of Medicine, is affiliated with the College of Medicine.

The Montefiore Medical Center has more than 2,000 acute care inpatient beds, over 60% of the 5,246 general care beds in the Bronx. Furthermore, in 1978, there were more than one and a half million ambulatory care visits in Bronx hospitals and 70% of all such visits were to the Montefiore Medical Center. Thus, our hospitals effectively serve as primary care sites for much of the Bronx population. Of the 10,850 long-term care beds (in 42 facilities) in the Bronx, approximately 2,000 of these beds are affiliated with the

Medical Center. In addition, the Montefiore Home Care Department has the sole Long-Term Care Home Health Care program (Nursing Home Without Walls) in the Bronx. The Home Care Department also includes a home health care program and medical services for three proprietary nursing homes.

Montefiore Medical Center has been a leader in many different areas of health care. In 1947 it established the first major home health care program in the country. Montefiore developed this country's first Office of Economic Opportunity-sponsored ambulatory care center and continues to operate ambulatory care centers in various parts of the Bronx. The Loeb Center for Nursing and Rehabilitation is preeminent in its field.

The Medical Center has been at the forefront in the provision of long-term health care to the aged, and Montefiore Hospital currently serves the highest proportion of Medicare patients of any major acute care hospital in the country. The health care of the aged and issues of long-term care policy are a major foci for the medical center. More than forty different geriatric programs encompassing the continuum of comprehensive long-term care, exist within the medical complex. Montefiore's chronic disease hospital, Beth Abraham, has pioneered a program using Physician Assistants in the long-term care of chronically ill older adults and is now embarking on a major project of chronic care management for long-term health care services.

SELECTED SPECIALIZED LONG-TERM CARE PROGRAMS

Beth Abraham Hospital, a 504-bed SNF affiliated with the Montefiore Medical Center, provides medical services and the whole spectrum of nursing home services to a population with heavy needs for skilled nursing care, many of whom would otherwise be hospitalized. The average age of the patients is 74.3. More than 90% are full Medicaid recipients. There are approximately 250 new admissions per year, most of whom come from medical center hospitals. Beth Abraham has a full-time medical staff with joint appointments with Montefiore and Albert Einstein College of Medicine. In addition to its inpatient services, Beth Abraham has developed a variety of new programs for individuals who do not need round-the-clock nursing care: These currently include Meals on Wheels for 100 homebound elderly and a sheltered workshop program. Programs being implemented in 1982 include; adult day care, hospice care, and home health care. Additional planned programs include: An intensive rehabilitation ward; geriatric screening program; ambulatory peritoneal dialysis; specialized services for persons with Alzheimer's disease and related dementing disorders; and transportation. Furthermore, Beth Abraham is engaged in renovating apartments to stabilize the surrounding neighborhood and in building a Section 202 senior citizen apartment building.

The Hebrew Home for the Aged at Riverdale has 298 health related beds and 653 skilled nursing beds, with 175 new admissions per year. A full range of clinical inpatient services are offered. Mean age is 85.6, and the whole spectrum of disease is represented, with arteriosclerotic heart disease and dementia being most prevalent. Average length of stay is 4 years 1 month. 98% of patients are covered by Medicaid. In addition to its inpatient services, Hebrew Home has a 137 unit Section 202 senior citizen apartment building (River House West), a sheltered workshop program and a homebound Meals on Wheels program. An adult day care program is scheduled for implementation in 1982. Hebrew Home is currently negotiating the takeover of an unoccupied 200-bed SNF building, Holland care. Estimated time of the first admission would be late Summer or early Fall.

Morningside House Nursing Home, located approximately 1/4 mile from the Medical School, has 190 health-related (intermediate care) beds and 196 skilled nursing beds, with 50 new admissions yearly. Inpatient services include medical services, nursing services, physical, occupational and recreational therapies, dietary, pharmaceutical and social services. Major diagnoses are: Congestive heart failure, arteriosclerotic heart disease, dementia, arthritis and diabetes. Most residents require some assistance with ambulation and approximately 200 need wheelchairs. Age range is 60-105 years, with a mean of 83.2. Population is female dominant (77%). Approximately 10% of the patients are Black or Hispanic. 95% of the residents are full Medicaid recipients. Morningside House is also affiliated with the Academy for Gerontological Education and Development (AGED), which provides the following community services: Meals on Wheels for 100 homebound elderly; a hot lunch program; an Information, Referral and Advocacy Program; a Transportation program; a Respite Facility; and a senior center with 1600 members.

The Montefiore Home Care Department is the sole Long-Term Care Home Health Care (Nursing Home Without Walls) program provided in the Bronx. Admission to this program is based on a comprehensive assessment of the patient's health status, social and psychological status and home environment and eligibility for placement by N.Y. State (DMS-1) criteria. Patient services include: Physician, nursing and medical social service visits; physical, occupational and speech therapies; nutritional consultation; respiratory therapy; audiology; personal care worker and/or home health aide; housekeeping and/or homemaking; laboratory, medications, and transportation. In addition, there are services not ordinarily covered under Medicaid, including home maintenance, respite care, social day care, social transportation, congregate or home delivered meals, moving assistance, and housing improvement. All services are available to patients according to their need, but total service costs must fall within the budget provision of the Lombardi Act (i.e., not to exceed 75% of the level of institutional care for which they qualify). The current patient population includes most diagnostic categories, with a predominance of circulatory and cerebrovascular disease. Half are over 75 years of age. Women comprise 75% of the group. Approximately 49% live alone. 85% are at the skilled nursing facility level; 15% at the health related level.

RECOMMENDATIONS TO THE VETERANS ADMINISTRATION FOR LONG-TERM HEALTH CARE PLANNING.

The Veterans Administration has long recognized the need to provide acute medical care for aged and disabled veterans and now is coming to terms with the need to provide long-term care. It should also go one step further - to examine the complex relationship between acute care and long-term care resources. The acute care hospital is one of many components in the array of long-term care services and has an important role in the care of the chronically ill patient.

With the dramatic increase in the frail aged (age 75 and 85) in New York State and the complex relationship between acute and long-term care institutional resources, i.e., both are operating at high occupying levels, acute hospitals have been confronted with a significant number of older persons, no longer requiring acute care. (NYS Health Planning Commission, 1982). Several steps can be taken:

. Development of geriatric screening teams to determine whether patients should be admitted to the hospital or diverted to alternate care settings.

. Development of Inpatient Rehabilitation or Staging Areas where a specialized geriatric inter-disciplinary team could provide active rehabilitation and management and/or continuing discharge planning.

These and other programs are based upon a causal model, i.e., specialized inter-disciplinary geriatric assessment and interventions improve the functional effectiveness of the older patient and contains health care costs (Eisdorfer & Cohen, 1982).

These are some key policy research questions to be answered before the V.A. begins long-term health care reform.

. Is there a shortage of nursing home beds and what are the consequences?

. What percentage of current V.A. nursing home residents could be cared for in the community if services were available?

. Do currently available screening and assessment instruments identify high risk populations in need of services and delay or prevent institutionalization?

. What programs and policies should be developed by the V.A. to maximize the independence of older persons needing long-term care?

. Can the V.A. develop incentives for the family to take care of older veterans in the home?

. What are the costs and benefits of providing home and community-based services for veterans?

. What should be the basis for projecting the needs of older veterans over the next 10 years?

. What are the costs and benefits of developing specialized programs for veterans with Alzheimer's disease and related disorders as well as their families?

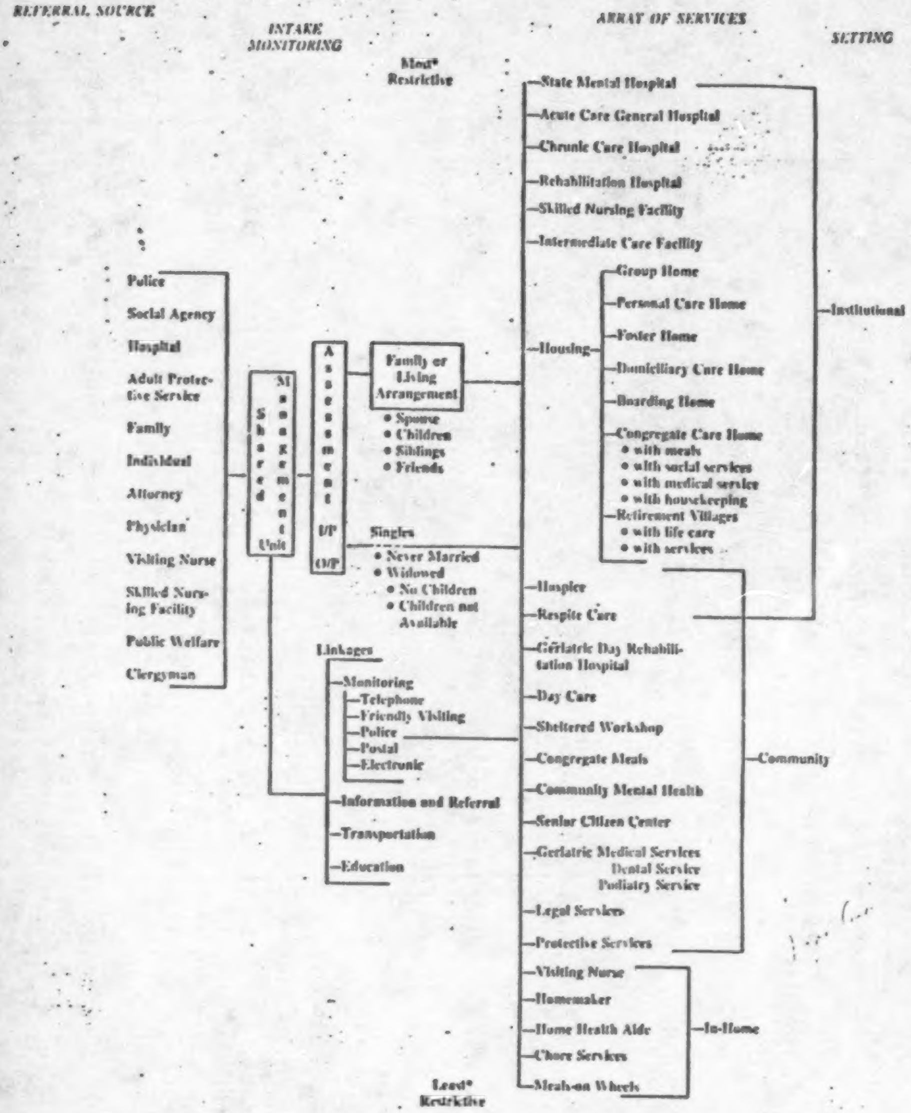
. What type of preventative services should be developed for veterans 60-75 years old, improve their health and decrease the future need for nursing home care?

. What are the unique roles of the V.A. acute care hospitals in long-term care?

. Can the V.A. implement a case management system to overcome fragmentation and assure cost-effective use of long-term care services?

CONCLUSION

We clearly need a program of community-oriented long-term disease management and disability prevention at funding levels similar to those of hospital and institutional care (Eisdorfer, 1981, p. 258). To ignore the impact of a larger and older population, most of whom have chronic illness and require the full range of "health" services, is to risk a serious crisis.


REFERRAL SOURCE
INTAKE MONITORING
ARRAY OF SERVICES
SETTING
Most* Restrictive
Police
Social Agency
Hospital
Adult Protective Service
Family
Individual
Attorney
Physician
Visiting Nurse
Skilled Nursing Facility
Public Welfare
Clergyman
Shared Management Unit
Assessment I/P O/P
Family or Living Arrangement
• Spouse
• Children
• Siblings
• Friends
Singles
• Never Married
• Widowed
• No Children
• Children not Available
Linkages
—Monitoring
—Telephone
—Friendly Visiting
—Police
—Postal
—Electronic
—Information and Referral
—Transportation
—Education
—State Mental Hospital
—Acute Care General Hospital
—Chronic Care Hospital
—Rehabilitation Hospital
—Skilled Nursing Facility
—Intermediate Care Facility
—Housing—
—Group Home
—Personal Care Home
—Foster Home
—Domiciliary Care Home
—Boarding Home
—Congregate Care Home
• with meals
• with social services
• with medical service
• with housekeeping
—Retirement Villages
• with life care
• with services
—Institutional
—Hospice
—Respite Care
—Geriatric Day Rehabilitation Hospital
—Day Care
—Sheltered Workshop
—Congregate Meals
—Community Mental Health
—Senior Citizen Center
—Geriatric Medical Services
Dental Service
Podiatry Service
—Legal Services
—Protective Services
—Community
—Visiting Nurse
—Homemaker
—Home Health Aide
—Chore Services
—Meals-on Wheels
—In-Home
Least* Restrictive

Inventory of Recommended Available Services, Appropriate to a Long-Term Care/Support System*

*The classification of from most to least restrictive is a general view of services and may vary within each service.

Fig. 2. Causal Model of Interdisciplinary Geriatric Family Assessment and Intervention and its Effect on Patient/Family Outcome. (Eisdorfer & Cohen, 1982)

CHANGES IN PROCESS OF CARE	CHANGES IN OUTCOME	
	COST	QUALITY
Orientation of Care		
. Careful & Accurate Assessment and Diagnosis of All Major Disorders and Problems	Decreased hospital stay	Improved Quality of Life and Improved Functional Status
. Appropriate Treatment for Acute Disorders	Increased Use of Home and Community-Based Resources After Discharge	
. Emphasis on Management and Rehabilitation	Discharge to Home and Community-based Care Instead of SNF placement.	
. Integration of Community-based Resources with Hospital-based Resources		
Providers of Care		
. Specialized Interdisciplinary Geriatric Team Assessment and Intervention	Increases in Professional Services Costs Accompanied by Increased Nonpaid Time with Families and Friends	Patients and Families will be more satisfied with care.
Locus of Care		
. Optimal Hospital Care followed by Appropriate Home-and Community-based Care	Utilization of Home and Community-based Care instead of Costly Re-Hospitalization or SNF placement	Improved Quality of Life and Functional State

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RESPONSE OF DR. DONNA COHEN, ASSOCIATE PROFESSOR OF PSYCHIATRY AND NEUROSCIENCES; AND HEAD OF THE DIVISION OF AGING AND GERIATRIC PSYCHIATRY, MONTEFIORE MEDICAL CENTER AND ALBERT EINSTEIN COLLEGE OF MEDICINE, BRONX, N.Y., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. Compare the VA's current policies, concerning the care and treatment of aging veterans, with the private sector's current policies concerning the care and treatment of the general aging population.

Answer 1. Since 1917, when Public Law 90 was enacted to provide medical and hospital services in its hospitals for veterans suffering from disorders incurred in military service, Congress has continued to enact legislation to change eligibility criteria and expand the array of health care services and benefits to veterans. Now the VA system faces the challenge to care for an increasingly older population. It is estimated that 45% of all American males over age 20 are veterans and by 1990 more than 50% of the U.S. males over age 65 will be veterans.

Neither the VA nor the private sector have developed effective policies to provide quality care for the aging population. All segments of society--federal, state, and local governments, labor, business, and the voluntary sectors--share with the older individual the responsibility for effective health policies and programs for the care of the aging and aged.

Current policies fail to deal with the pressures on health care, especially long term health care, generated by three basic demographic factors: increasing life expectancy of the aged, the prevalence of chronic disease, and the change in the American family, e.g., more working women, postponed marriage, more divorce, fewer children, increased mobility.

A new policy is needed that is (1) responsive to the health needs (medical and social) of the population and the altered family structure; (2) creates and sustains health management programs which improve the quality of life and functional effectiveness of older persons; and (3) establishes cost-beneficial procedures which are equitable for acute care and long term care as well as home care and institutional care.

If the members of this committee are concerned about the long term quality, efficiency, and economy of the VA health care system, major health policy reform is required. Important issues must be addressed to implement reform: (1) How much should be spent and on whom? (2) What types of programs promote health and wellness as well as treat illness and disease? (3) How can these health programs and systems be managed and financed? (4) What criteria should be developed to make decisions about the assimilation of new technologic discoveries into health care? (5) What training programs should be implemented to educate professionals in health planning and management?

Question 2. In your capacity as a specialist on aging, what combination of needs do you anticipate this aging veteran population will have, and what array of health and social support services should the VA provide in order to best provide care for the population?

Answer 2. The health experience of older veterans are different from younger segments of the adult population.

I. Needs

A. Health Maintenance and Health Promotion

The aged, especially the young old (65-74 years) are relatively healthy and concerned with maintaining their health;

B. Management of Chronic Illness

Older persons who become sick have a combination of acute and chronic disorders and disabilities. Multiple disorders affect multiple organ systems and treatment of one disorder may aggrevate a co-existing condition or provoke a problem in another system.

The current VA health care system does not reach out to the older population and let them know how the system can serve them.

C. Psychiatric and Behavioral Disorders

Approximately 15% of the aged in the community and 70% of those in institutions suffer from significant psychiatric and behavioral disturbances. These may be the major cause of disability or they may co-exist with physical disorders. The major psychiatric disorders are reversible as well as non-reversible dementias, depressive disorders, schizophrenia and paranoid states, anxiety disorders, drug abuse and alcoholism, as well as neurotic disorders. Although older persons account for 17% of the population they account for more than 25% of all services.

D. Assistance to Overcome Multiple Impairment

The aged with physical and mental health problems are frequently functionally impaired, socially isolated, and economically disadvantaged. Social and economic dependency and impaired functional status are the major determinants of whether an individual continues to live independently in the community or is institutionalized.

E. Humane Terminal Care.

F. Dental Health.

Oral health must be seen as an important part of total health care.

G. Older persons must be treated with dignity and respect and regarded as a resource to society, not as frail, frail, dependent, and useless.

H. Nutrition.

Need for adequate nutrition is seen as one of the most important factors for improving health status of the aged in the 1980's.

J. Accessible health care system.

K. Minority needs.

The health experience of the minority aged, especially of Black, Hispanic, and American Indian differ from the Caucasian aged.

II. Principles for developing policies and services to meet needs of the aging and aged veteran.

A. Prevention and health management should focus on maintaining or reestablishing a maximum level of functioning.

B. Institutionalization should be avoided when possible.

C. A combination of social, community, and medical services are required to maximize functional effectiveness and the quality of life.

D. Rehabilitation should not be regarded as secondary to medical services.

The demands for such services will increase as a result of advanced research resulting in organ transplants, electronic implants for deafness and so on. The high cost of providing rehabilitation services in hospitals and nursing homes could be controlled by the implementation of extensive coordinated community based services.

III. Array of Services

A. Health screening to assess change in physical and mental health.

B. Rehabilitation services.

C. Interdisciplinary medical and psychiatric services.

D. Dental health services.

E. Research on health maintenance and health promotion.

F. Social services and informal supports for veterans and the family. Programs should take into account the contribution and role of family and informal supports which allow the individual to function independently.

G. Home and community based services.

A full range of home and community-based services are necessary to facilitate older veterans living in their own community.

H. Linkages, access, and follow-up.

The health support system should be well-organized to facilitate access to needed services.

I. Diversity and choice. Special attention should be focussed upon the various family and cultural patterns of living that exist among the aged population. The older veterans should be able to make decisions which affect their treatment alternatives and daily lives.

J. New service programs. Attention should be given to such programs as respite care, day care, hospice, congregate care and enriched group living arrangements.

K. Primary care. Integrated, interdisciplinary geriatric health care teams should be developed to provide comprehensive care.

L. Humane terminal care should be seen as an essential component of quality health care.

M. A long term care coordinating program should be established to coordinate long term care for the veteran aged and disabled on a community basis.

N. Training in geriatrics should continue to be promoted and supported.

O. Research in aging and geriatrics should be increased to improve our knowledge base and deliver more effective care to the aged.

The attached table lists an array of services which may be useful to care for the needs of aging veterans.

Question 3. Do you believe that an array of services exists now within the VA health care system?

Answer 3. The hospital and institutional based services exist with the VA health care system.

Question 4. Would you change or re-direct the VA's program that treats its aging veterans? If so, how?

Answer 4. The quality of acute care and long term care needs to be addressed, and a comprehensive long term caring health system needs to be implemented. Many acute care facilities are expanding their mission to include delivery of a range of non-acute care health and human services. Should VA policies lead to diversified services for the aging veteran? The target population, i.e., the aging veteran population, has been defined and the elements or services are contained within the VA system. A system development phase is needed to define policy issues, develop alternative solutions, evaluate the alternatives, and implement new programs through the GRECC's.

On a practical level, there is the need to develop a comprehensive needs assessment instrument as a first step in care-planning for the individual. Chronic care management units should be established to do care planning, broker services, monitor and re-assess the individual.

The VA should develop interdisciplinary geriatric consultation teams for inpatient and outpatient evaluation and treatment. Each acute care VA hospital should develop a special staging unit for older patients who no longer need acute hospital care, but do require active rehabilitation and maintenance efforts.

A major emphasis should be placed on health promotion.

From infancy to old age, studying health is a major challenge. Age-related risk for illness and disease are misleading. Although heart disease, stroke, and cancer are commonly regarded as adult health problems, their roots and those of many chronic diseases are found in early life. Early eating patterns, exercise habits, and exposure to toxic conditions and substances all affect the likelihood of developing disease later in life. At each stage of life, different steps can be taken to maximize well-being. According to the Surgeon General's Report (1978), a major improvement in health, mobility, and independence for older people could be achieved by reducing by 20% the average number of days of illness in this group.

Question 5. What barriers do you believe exist in the VA health care system which may prevent "deinstitutionalization" of its aging population?

Answer 5. A. Lack of thoughful data-based policy formulation and planning

B. Mission conflict

C. Internal organizational linkages

D. Attraction of medical staff and administration

E. Lack of personnel training in geriatrics

Question 6. Are community-based programs, which provide health and social support services available throughout the nation?

Answer 6. They are not available throughout the entire United States, but models of community based programs do exist. They vary as a function of many factors, including the size of the community, the presence of a major teaching hospital as well as clinical and community resources.

See attached information on home health care service.

Question 7. Would you comment on the effectiveness of the present role of the VA GRECC's in the agency's overall program of providing health care to eligible veterans? Please address each of the three program areas of geriatric care, i.e., research, education, and clinical activities.

Answer 7. Dr. Busse is far more knowledgeable to comment on the GRECC's.

Table 1. Utilization of Services Resources and Health Delivery Structure

	SERVICES
Frail, Independent Older Persons Living at Home	Clinic Care Adult Day Care Homemaker Assistance Housekeeper/Chore Service Nutritional Services Transportation Information & Referral Legal Services
Chronically Ill, Semi-Independent Ambulatory Aged Receiving Symptomatic Medical and Social Care	Home Health Service Home Health Aide Day Treatment Enriched Housing Adult Homes Special Homes Personal Care Programs Sheltered Workshops Personal Care Home Delivered Meals
Institutionalized Aged	Psychiatric Hospital Skilled Nursing Facility Health Related Facility
Older Persons Dying	Hospice Home

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Geriatric Home Care: For Whom. How Long. How Much. What Then: Analysis of a Set of Patient Records for Forecasting Geriatric Home Health Outcomes from Personal, Familial, and Systemic Variables

Michigan Univ, Ann Arbor

Prepared for

Health Care Financing Administration
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Jan 81

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15. Supplementary Notes

16. Abstract (Limit: 200 words)

This study attempted to examine the natural history of home health care service use from entry to exit, and to document the status of clients following home care in terms of types of services used at discharge. In this one-year grant the case records of over 2,000 older adults served by the San Francisco Home Health Services, Inc., between 1968 and 1975 were analyzed. Variables of interest included entry pay plan, referral source, whether or not on public assistance, year of receipt of service, duration and intensity of services. Multivariate analyses was used to analyze the data.

Pay plan was shown to be the predominant predictor of utilization, followed by personal condition. Likelihood of discharge to self care was far higher for short-term than for long-term clients; those with higher intensity services within each public pay plan tended to enter institutions or to die. Each pay plan category had unique utilization characteristics. Previous source of care was more useful in accounting for exit situation and duration than intensity; referral source, living arrangement, sex were small influences in explaining proportion of nursing visits. This study indicated that future research should separately assess duration and intensity of home care.

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GERIATRIC HOME CARE:

For whom? How long? How much? What then?

December, 1980

Health Gerontology
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GERIATRIC HOME CARE: FOR WHOM? HOW LONG? HOW MUCH? WHAT THEN?

Executive Summary

This study analyzed the case records of over 2,000 older adults served by the San Francisco Home Health Services, Inc. between 1968 and 1975. The natural history of service use from entry to exit is observed, permitting identification of distinct types of service use. Most research and demonstration studies of home health care have concentrated on clients eligible for in-patient care who are substituting home care; they have measured the functional status of patients over a predetermined span of time.

Half of the clients studied here were served 6 months or less (1/4 2 months or less) with near half of these returning to informal (self or family) care. This study documents the status of clients following home care in terms of types of services used at discharge. The majority of cases entered under Social Service pay plans, with just over 1/3 on Medicare and 1/4 on private or charitable funds. Measuring utilization required separation of duration in months, number of visits per month, and proportion of all visits which were visits by a nurse. Average intensity of visits was below 2 per week, with the ratio of nurse to aide average 1:5.

Duration of service and intensity of visits were found in multivariate analyses (SEARCH and multiple regression) to be more distinguishable by entry pay plan than by any of the other independent variables: age, sex, living arrangement, public assistance, referral source, prior locus of care, or use of nursing visit in first month. The proportion of variance explained by one or a few entry characteristics was small. However, means were significantly different for both months of duration and proportion of nursing visits when exit-by-payplan categories were separated. Pay plan regulations are linked to intensity of services eligible for reimbursement. Exit status categories differed more on duration than on intensity. (These differences are shown in Table 13 and Figure 12, pages 59 - 63 of report.)

Those who entered on Medicare tended to use services more intensively than others, and were likely to leave sooner. Those who entered under State pay plans averaged longer duration on home care with far lower intensity than others. The clients whose entry pay plan was non-public used intensity of nursing similar to the Medicare clients and number of visits per month more like the State clients; length of stay averages were shorter than others. While entry pay plan would not be the continuing pay plan for all clients, it is a pragmatic separating characteristic for pattern of service use. Each entry pay plan population has distinct proportions of clients entering home care from hospital/ECF care vs. prior care at home; the latter remain on the home care for longer duration. Intensity of care is unaffected by prior care setting, and more likely to be a function of patient condition and living arrangement, in addition to pay plan as discussed above.

Implications of these findings are discussed both in relation to the methods for establishing cost-effectiveness relationships and in relation to policies aimed at reducing unnecessary institutional care. While this study of one agency's geriatric clients cannot be immediately generalized, the home care is shown to prevent and postpone nursing home use for clients willing and able to receive community services.

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Geriatric Home Care:

For Whom? How Long? How Much? What Then?

Analysis of a set of patient records for
"Forecasting Geriatric Home Health
Outcomes from Personal, Familial,
and Systemic Variables"

Suzanne Rie Day, M.A., M.P.H.
Project Director

December 1980

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Dr.P.H., Principal Investigator,
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Although the exploratory learning process represented in this report has been a long individual pursuit, a very broad community of interest surrounds the effort, and people more numerous than I can mention here have contributed.

Early stages were assisted by Doris Schwartz and Sylvia Peabody, respectively Directors of Visiting Nurse Associations in Wilmington, Delaware and Detroit, Michigan. Judith (LaVor) Williams facilitated locating the case records, and both Brahna Trager and Catherine Ricker-Smith were cordially encouraging that further analysis follow their painstaking efforts to document actual service utilization.

Encouragement and administrative support from Tom Hickey made the project operate smoothly; the many facilities and supportive services of the School of Public Health reduced technical problems to a minimum. Statistical and computer programming advice from Ken Guire and Jerry Hiniker were indispensable, and the able assistance of Susan Blalock brought details together admirably.

An aspect of the project which contributed to the shape of this report, and which was a stimulating experience for all involved, was a seminar on the issues of measuring use and defining expectations in home care research. With appreciation, and a sense of so much more to be done, I acknowledge the contributions of Frank Caro, George Greenberg, Jay Greenberg, Barbara Hicks, Korbin Liu, Laura Reif, Alan Sager, Albert Skellie, and, Philip Weiler. Bettina Kurowski offered useful comments in absentia.

H.C.F.A. Project Manager Marni Hall gave more than routine attention to the progress of the project, which was useful in shaping the presentation. Format of the finished copy can be attributed to Roberta Robakiewicz and Nancy Neville, whose patience and perseverance are laudable.

For the shortcomings, omissions, and interpretations I bear responsibility. Since the issue and even these data will continue to receive my attention, I would welcome communication from readers.

S.R.D.
Ann Arbor
December 1980

SUMMARY

Care for the disabled geriatric population is receiving increasing attention as a public budget issue. Information useful for projecting demand for the several types of care appropriate for geriatric services is far less developed than information on the utilization of acute hospital beds. Regulations which surround subsidized funding for health services are widely acknowledged to influence the entry of older persons into particular types of care; however, little information is available about the relationships between funding sources and utilization patterns of geriatric patients. Because precise definitions and theoretical frameworks have often been missing, ambiguous findings have emerged from most studies designed to inform public policy makers about the potential costs and effects of various services. People who are cared for at home may be receiving simultaneously care from more than one source, especially when the informal assistance of family or friends is considered.

Older people who use formal agency services for home health care (HHC) vary widely in personal characteristics. They utilize a variety of services over differing lengths of time. After a period of using services at home, some will continue to use care available in the community, others will have been discharged, died or transferred to institutional care. Very few studies have been published on the status of older patients following a span of care by home services. This report maintains that among measures of effectiveness of community-based services as alternatives to nursing home use, is the situation of client at end of utilizing formal home care. Any expectation of assessing the cost-effectiveness of care rests on defining some criterion effect and measuring intensity and duration of service utilization as indicators of cost.

If relationships could be identified between certain characteristics known at the time clients enter HHC and their utilization patterns and status at discharge, then policies might develop which acknowledge the effects of important patient and service variables. At least some of those significant relationships might be influenced by changes in public programs which surround the delivery of services to older adults.

The present study examined the service records of geriatric clients of an urban home services agency to test hypotheses that 1) personal characteristics will be relatively less influential than economic and service context on utilization of home care and, 2) the relationships between service use and status at discharge from the agency will show those with higher intensity services more likely than others to be discharged to self or informal care. Both of these hypotheses were expected to apply to relatively short-term utilizers of HHC, with long-term clients showing contrasting relationships. Related questions to illustrate the importance of such characteristics as service interruptions were explored.

Results generally support both hypotheses. Those who entered on Medicare used highest intensity of services per month. Pay plans differed in duration and intensity. Those discharged as improved and leaving to informal care averaged short duration and moderate intensity of care, with large proportion being post-hospital (recuperative) cases. The intensity of care for those whose exit was institutional care, and those who died averaged service more intense than others, and their length-of-stay was longer than others. About one-third of the geriatric clients entered nursing homes or hospitals, about one-third left to informal settings; less than 20% died, and about 20% were referred to other formal services in the community.

Since the data used for this study were from a single agency, including clients receiving only chore services, results must be considered suggestive rather than definitive of home care. Disaggregating utilization into measures of duration and measures of intensity appears clearly necessary to long-term care research. Although separating a service population by indicators of case-mix is recognized as basic to relationships between services and expected outcomes, pragmatic categories for non-facility-based care have been lacking. Multivariate analysis of these data suggest that regulations surrounding subsidized payment for geriatric services may provide gross separation of client types useful for forecasting service utilization. Since dissatisfaction is widely expressed over current funding regulations, these categories must not be construed as homogeneous on any criterion of need for service.

This study sought to explore relationships among and between personal and contextual variables, to consider the implications of formal home health services as either a complement to or a substitute for informal care at home, and to examine the distribution of discharge reasons as a major consideration in the assessment of "alternatives" in the spectrum of long-term care services. Following a brief preamble from the literature, the hypotheses and research questions will be introduced. Then the methodology for the study will be explained, acknowledging questions and issues which were not pursued in this project. Explanations of variables and of the records from which the cases were drawn will be developed before presentation of selected findings.

I. THE BACKGROUND AND EXPECTATIONS FOR THIS ANALYSIS

A. Public Issue: Searching for Relationships

Some national policy makers warn that broadening Medicare entitlement for home health services could produce a flood of demand which would overwhelm supply, quality control, and fiscal management (Congressional Budget Office, 1977; DHEW in National League for Nursing, 1977). Others declare wider use of HHC to be imperative for cost containment and appropriate matching of problems to sources of care (DHEW, 1976; Dunlop, 1975, 1980; GAO, 1974, 1977; U.S. House of Representatives, 1979).

Quite a different impact would occur on the market for home care services depending on whether the larger proportion of families were to use HHC as a complement to their own care or to withdraw from providing services, using agency HHC as a substitute for family care. This issue has received attention in the literature primarily with research of the, "What would you do, if..." design (Bell, 1973; Sager, 1980; Sussman, 1978). Hypothetical findings are less convincing for political purposes than behavioral documentation; a major incentive for the present study was its potential for documenting actual patterns of observed activity of geriatric home care clients.

A primary question which plagues Congress and the Administration is, "If home health benefits were publicly subsidized more liberally than they have been in the past, what controls would be needed to assure that they were used appropriately?" More specific questions such as, "Would eligibility for formal home care services cause a decline in the availability of unpaid care at home? Would home care service substitute for at least some institutional care, or would home care constitute a net increase to program costs?" These questions reflect how the issue is defined within the public subsidy sector of government planning. Clearly, the definitions of "appropriately," "substitute," "availability," and even "unpaid" and "program costs" involve value orientations which need to be brought into open dialogue. When "effectiveness" is to be assessed, there is likely to be a wide range of difference in expected or desired effects depending upon roles and values of those forming the definitions. An early implication of the movement to shift public funding away from "over-institutionalizing" geriatric patients was that dollars saved from inappropriate nursing home use could cover a wide spectrum of alternatives. Now planners are less certain that future costs can be contained while services are broadened.

Policy for long-term care is surrounded by a complex set of natural and cultural uncertainties. Policy analysis attempts to reduce uncertainty by bringing empirical data into focus around aspects of a problem which are identified as significant to its amelioration. Part of the appropriate process for such focus in long term care may be the separation of variables which are amenable to near term policy influence from those which are states-of-nature or unlikely to respond to human intervention. Basic to planning research is an expectation that alternative paths may be chosen to reach a given objective. In policy for care of geriatric patients, however, there is lack of consensus on the objectives.

An important criterion for public involvement seems to be that new areas of subsidy stem the tide of "unnecessary" institutionalization. If an objective of public support for community-based care is that unnecessary use of institutions would be reduced, then outcome measures should include indicators or whether, or for how long, home care keeps people out of institutions. The research reported here separates personal characteristics of clients, which could be considered states-of-nature, from the situation surrounding entry, which might be amenable to change through alternatives in subsidy or service delivery. A major purpose of this study was to examine the distribution of further services at the time home care services were concluded. From a planning perspective the specific changes in functional status of geriatric patients seem much less important than the resources needed to address their functional disabilities; the distribution of exit conditions, then, is examined here in terms of sources of service (if any) following formal (agency-delivered) services at home.

B. Literature Views Parts, but Rarely Relationships

The premise, set out in the early response to developing alternatives to long-term institutionalization of chronically disabled older people, was that certain measures were needed (i.e., population need, amount of utilization of various types of services, costs per service type), and that, with such measures, calculations could be similar to those made by hospital facilities planners for acute care beds. The complexities of demand and supply in home care, and their relationship to objectively assessed need, have not yet been set into a model whereby changes in geriatric need could be projected into demand through specific indicators of service utilization. Although this problem is not unique to geriatric services for long-term care, increased complexity and uncertainty is added to planning geriatric services when it is recognized that fluctuations in health and multiple chronic conditions increase with advancing age. Unlike hospital "bed days" the community care setting leaves service measurement and effectiveness measurement both to be defined.

The question of effect of HHC services on clients and their network of informal help is complicated by the continuing chronic conditions of many HHC clients and the difficulty in defining a specific outcome measure. Nielsen, et al. (1972) used outcome measures of morbidity, contentment, and rate of institutionalization. In a New York State survey (Van Dyke and Brown, 1972) 75% of community care patients visited at home had conditions from which they were not expected to recuperate. And yet the cumulative results of several studies of reasons for discharge from home health care show that the majority are returned, after a period of service, to self care or family care (see Table 1). Obviously a longitudinal dimension is essential to the interpretation of discharge surveys: conditions at 6 months from entry would be expected to differ widely from distribution of conditions noted after long periods of service.

Early empirical studies of home health care services concentrated on the effect of those services for reducing hospital stays (Bryant, et al., 1974; Hurtado, et al., 1969, 1972; Gerson and Hughes, 1976). Some efforts have been made to explore the potential for home care programs to shorten or prevent nursing home use (Brickner, et al., 1977; E. Brody, et al., 1977; Katz, et al., 1972, 1977; Kraus and Armstrong, 1977). These studies have rarely elaborated on any of the three variables which perhaps make the greatest difference in whether or not HHC could become a viable substitute for either hospital days or nursing home stays. These are: (1) policies of the agencies themselves concerning the types of patients admitted to care; (2) kinds of services provided, amounts of various services used; and, (3) reasons for termination of cases. A brief discussion and research commentary follows on each of these areas.

1. Agency Differences and Differing Patient Profiles

Although the studies shown in Table 1 are not exactly comparable, their juxtaposition illustrates how differing entry policies, service patterns, and discharge arrangements affect distribution of discharge status. For example, the Cleveland VNA clients appear to be acute and terminal cases while the CIC clients were more chronic care cases; the Saskatoon program readmitted a large portion to the hospital, (most having been hospital referrals), whereas the Chelsea Village program is an outreach program from St. Vincent's Hospital to help maintain frail elderly at home. The California cases were both "retained" and discharged, while the Massachusetts study was only of those discharged alive.

Table 1

Published Reports on Distribution of Patient Status Following Home Health Care Service use (Periods of Use Vary)

Study: Authors, Locale, and Date Reported	No. Discharges (may include duplicated persons)	Status of Home care Patients at Time of Research					
		Discharged as Improved	Stable, Service Continued	Deteriorated Status· Discharged		Died	Other or Moved Away
				Nursing Home	Hospital		
Hunt and Chrichton 1977 Saskatoon	N=2171	27%	20%	5.5%	37%	5%	5.5%
Robinson and Caso 1975 Massachusetts	N=3691	75%	-	2%	19%	-	-
Stiefel 1967 New York	N=2000	59%	4%	2%	30%	4%	1%
Kraus and Armstrong 1977 Western Ontario	N=218	22%	40%	12%	22%	2%	2%
Brickner, et al. Chelsea Village New York City 1975	N=184	11%	62%	8%	7%	4%	2%
Noelker and Harel 1978 Cleveland	N=55VNA N=55 CIC*	5% 8%	42% 62%	- 13%	-	30% 4%	23% 13%
Ricker-Smith and Trager, 1978 California State 1973 Discharged and Retained Case	N=66334	45%	28%	2%	16%	5%	4%

*Chronic Illness Center of Cuyahoga County Hospital System

Some agencies only handle short-term cases, while others maintain clients at home for many years. Both Mims (1977) and Trager (1975) found over half the clients had received services for over one year. By contrast Hunt and Chrichton (1977) noted 65% of cases had less than 90 days duration, and Hurtado et al., (1972) note length-of-stay increasing with advancing age. With much of the care to geriatric patients paid for through public subsidy, the financial and service regulations which surround an agency's delivery of care make a significant difference in its policies on admission and retention of clients. A hospital-based home care program serving patients under hospital insurance is likely to have more rapid turnover of clientele than a service agency in a community dedicated to providing supportive services with charitable funds to supplement Medicare, or other insurance payments, which are strictly circumscribed.

The questions surrounding costs of care clearly differ by type of agency. Services delivered in an institutional setting may fluctuate in intensity, but costs are incurred every day. When services are used by persons living at home, there is more likelihood for fluctuation and even interruption of service. Over the long-term, a per diem cost analysis may have very little meaning.

Gerson and Hughes (1976) examined the costs of home and hospital care for patients recuperating from serious conditions. They concluded that indicators of medical conditions were just as satisfactory at home as in an institution; costs were close to equal; and home care programs could prevent capital expenditure for costly in-patient beds. Hunt and Chrichton (1977) reported that in an agency providing home services over several years, the average cost of care per client day declined as the program became larger. In a study designed to examine costs per home care episode hospital-based Philadelphia agencies were found to have higher costs, than Massachusetts agencies; this was discussed as due to both case-mix and accounting differences (Kurowski, et al., 1979). When the period of study is limited to a few post-hospital months (as in the Gerson and Hughes study), or to a pre-determined period of months (12 or less in the Kurowski study), then intensity of service visits in the observed time period will be the major determinant of total case costs. The very nature of long-term care, however, is that it may persist over years. For the study of the relative impact of duration and intensity on costs it would be necessary to examine these variables independently and interactively.

2. Service Delivery Patterns and Patterns of Service Use

In one of the more comprehensive and analytic considerations of HHC, Morris (1974) stated three assumptions necessary for "efficient and economical" home health care: high reliance placed on less professional rather than therapeutic staff; patients and their families are in control of daily decisions about care; and average volume of service approximately 10 hours per week per client.

Additionally, he emphasized the importance of the intangible quality of motivation, which propels some patients and families to seek agency help while others, similarly disabled, may eschew services altogether. Some demonstration projects have found potential clients hesitant to seek or to continue services despite objectively sufficient need (Barney, 1977; Nielsen, et al., 1972). Nielsen goes on to recommend that further research seek to establish what amounts or patterns of care might be a "minimal effective dose" of home services. These studies link the variables surrounding choice to receive HHC with the variables surrounding outcome of care; clients who use HHC may differ from those who avoid services altogether or enter inpatient facilities.

Studies, including Wisconsin Community Care Organizations (Seidl,et al.,1978) and the national 222 Experiments (Weissert, et al.,1979), which were designed to examine home care as a means of postponing or preventing institutional care, have found lower demand for such alternative care than had been expected. The literature on behavior vis-a-vis health services, primarily focused on acute care, has little to say about the refusal of, or withdrawal from chronic care services. The Health of Older People (Shanas, 1962) found older adults themselves were far less likely than their younger relatives to expect that medical care would relieve their health problems. Even when a home health agency is contacted for geriatric care, many factors influence whether or not service is initiated, what personnel (therapist, nurse, homemaker/home health aide) are used at what intensity, for what duration (Robinson,et al.,1974).

Not only do HHC agency policies influence the characteristics of their clientele, but they directly guide the allocation of staff time and resources for delivering care. Considering the strong policy directives toward cost containment, it is significant that many surveys of service users suggest that there is a serious deficiency in both availability and use of home aide services. This underutilization of aides appears to be due both to traditional patterns of service delivery and to categorical funding and subsidization of specialized services (G.A.O., 1977b; Lyman, et al., 1974; Morris & Harris, 1974; Nash & Arno, 1976; Trager, 1971; U.S. Senate, 1977). Differences in agency management are illustrated by comparing a Detroit study (Levenson, 1975) and a Minneapolis study (Greenberg, 1974) where the former--a Visiting Nurse Association--used an average of 9.0 visits by professionals and 0.9 visits by home aides per case. The Minneapolis ratio was reversed, with the most impaired receiving one nursing hour per 6 hours of aide when the recipient lived with someone, and one nursing hour per approximately 10 hours of aide service when client lived alone.

Since agency policies have a strong influence on the characteristics of clients admitted to service, it may not be surprising that wide differences among agencies are reported on such factors as household composition or diagnosis/prognosis. While certain agencies may be likely to serve primarily clients with family, the reports on geriatric use of HHC suggest that a large population of users are living alone (Brickner, et al., 1975; Katz, et al., 1977; Kraus, 1978; Trager, 1975). There are indications that, when physical condition is impaired, an older person who lives alone is more likely to enter a nursing home than a similarly impaired person who lives with others (S. Brody, et al., 1978; Nielsen, et al., 1972; G.A.O., 1977a). The G.A.O. report shows that among the greatly or extremely impaired who were not institutionalized, 29% were married, and another 25% lived with children. The same report shows families provide over half the care at every level of impairment to disabled older people, and over 80% of the care of the noninstitutionalized extremely impaired clients of home care agencies. Disaggregating "living alone" from various other factors affecting health and social status is usefully discussed by Dunlop (1976); the influences of poverty, widowhood, informal resources may be as important as living alone in accounting for varied service use.

Physical condition of the clients cannot be clearly determined by diagnosis, but those studies which have reported diagnosis provide some indications of the multiple problems, and often generalized difficulties, of those who turn to home health care. Hale and Jacobs (1976) looked at records of eight agencies and found the most frequently listed diagnosis was "general" followed by "no abnormality" and "cardiac/circulatory." When the hospital-based records reported by Hunt and Chrichton (1977) were examined for diagnosis, "nervous system disorders" were the most frequent, followed by musculoskeletal disease, injury, and heart and lung problems. Using the Barthel Index of functional capacity, Wartski and Green (1971) found half the HHC clients to be in the upper level, and about a quarter each in middle and low levels. This corresponds to the findings of Brody and colleagues (1978) that the seriously impaired tended to be found in institutions rather than in home services. Only one third of the clients in a New York

City study were functionally dependent for personal care (HSA/VNSNYC, 1977), and in that study 10% of the patients used 47% of the services. The Minnesota comparison of nursing home and home care clients found home clients less disabled than skilled nursing home patients, but more disabled than intermediate care patients in nursing homes (Anderson, et al., 1980).

Functional disability is now widely recognized to be more useful information for assessing need for services than diagnosis, particularly for geriatric chronic conditions. Patient care planning requires information on functional level, and formal service utilization patterns would be expected to be correlated with functional disability combined with deficient informal resources to meet needs for care. Patterns of care also differ depending on how long a client has been receiving HHC. Looking at a population of chronically disabled persons receiving community care, Katz, et al., (1977) found that after an initial six months' period of care, 87% received the same level of service in the second six months of service, 11% received less, and 2% received more service. But overall there was a reduced manpower demand; fewer high cost services were used as time elapsed.

The complexity of relationships between client characteristics, agency characteristics, and utilization of services clearly expands as one becomes familiar with the number of variables which influence service use. The literature does not contain reports with sufficient detail to account for the effects of agency policy, age, and functional level of clients, influences of payment sources, simultaneous services of other providers--including family and friends, alternative services available and professional and personal advisors. The providers of care need efficient record keeping and the researchers of care need adequate detail in records to sort out complex phenomena; many systems are currently under development for increased documentation for long-term care (see Part II).

3. Status of Client Following Home Health Service

Very little information appears in the literature on distributions such as those shown in Table 1. It seems that functional level has been the variable of pervasive interest in the literature on "effects" of community services for geriatric patients. Little claim is made that nursing homes enhance the functional status of their residents, yet the criterion in study after study of "alternatives" is level of patient function as a measure of the program's "effect".

Functional status is likely to be a predictor of the propensity people have for entering health care; it is, at best, an uncertain measure of the outcome of chronic care. Mitchell (1978) found initial condition the strongest predictor of condition three months later, and Wylie (1967) found differences in stroke patient outc~~ome were~~ more closely correlated with condition at initiation of care than with differences in services delivered. If this is true for certain acute recuperation, it may be expected to be even more relevant to chronic care. And in chronic care the incoming condition must include resources available for service and outcomes must include not only functional status but need for continuing care.

The availability of informal services to patients at home has been increasingly recognized, and the impact of milieu on behavior, mood, and role performance commands a literature of its own. In retrospective summary of their extensive quantitative report on years of experience with hospital-coordinated home care, Hunt and Chrichton (1977) comment:

> Experience has shown that not only do older patients prefer the home setting, but often recovery there has been quicker and to a greater degree. Physical and mental deterioration have appeared to be less rapid and extensive than in institutional surroundings (p. 1354).

If condition at exit from care varies by entering situation, then separating clients into entry types is clearly useful.

To distinguish patients with various conditions at initiation of service, Kurowski et al. (1979) separated cases into classes by "purpose of home health services": rehabilitation, recuperation, terminal care. It was only the rehabilitation group for whom the variables studied were able to account reasonably for variation in costs of care. Although standard regimen was posed as explanation for these findings, it may be equally expected that persons using home care for rehabilitation have different informal support resources, payment plans, mental and physical resources when compared to recuperative and terminal home care clients or to rehabilitation clients who enter nursing homes or special institutions. Clearly a variety of client types exist within the service system labeled home health care, but rehabilitation, recuperation, or terminal care may fluctuate across a long-term client's service history. It is this fluctuation which makes assessment of effects of services by functional level of geriatric home health clients seem far from adequate for planning public programs; some care may be rehabilitative, some clients may recuperate, but others will need varied amounts of care for various purposes over extended periods of time.

In acute care programs outcome can be defined as condition after a "spell of illness" or after a period of treatment, although health status and disability measures are still frontier areas for study. The movement to define and measure outcomes takes on especially troublesome aspects in long-term geriatric care. Although rarely discussed in long-term care planning, death is the one assured outcome at the end of a "span of life." Expectations that long-term care programs be assessed by rates of cure, maintenance of function, slowed deterioration seem to be borrowed inappropriately from curative medicine (Boulding, 1966).

Would agreement ever be attained for standards of just how much, or for how long functional ability should be maintained? For chronic care there need to be different priorities than for curative care, and objectives set to fit those program priorities or purposes. When outcome is not expected to be curative, new definitions of effect are needed. Home health services may be providing both long-term, chronic care and acute, therapeutic care. This diversity has been underlying much of the public policy debate about how much geriatric home care is health-oriented and how much is social service.

The way to assess status at discharge from home health service which seems most useful for planning purposes is to distinguish what types of services, if any, are demanded from formal sources following the use of home care.

C. Design for Retrospective Analysis of Geriatric Home Care

Given the policy questions and the issues left unresolved in the literature, a retrospective analysis of geriatric home care utilization was designed to: 1) examine the relationships of variables at time of entry to utilization of services and, 2) to examine the relationship of service utilization to situation at time of discharge.

Hypotheses and research questions to explore these relationships for geriatric home health clients were the following:

Hypothesis 1.

Entering characteristics of a personal and familial nature will show a weaker relationship to intensity of service than factors such as source of referral, previous locus of care, type of payment.

1a. What are the strongest predictors of intensity of services?

1b. Do those relationships differ for short-term and long-term clients?

1c. Do those relationships differ by status of client at discharge?

1d. How do clients who utilize home care services intermittently differ from those whose use of home care is continuous?

Hypothesis 2.

The likelihood of discharge to self-care will vary directly with service intensity for short-term clients. The relationship will likely be reversed for long-term clients: high intensity services will be associated with reduced likelihood of discharge to informal setting.

2a. Does the proportion discharged to self or informal care differ for clients who use high-intensity service over a short period, compared to those whose high-intensity service persists over a long period?

2b. What characteristics discriminate between those clients who are discharged for nursing home care, informal care, or other reasons?

2c. Are different utilization histories distinguishable for different reasons for discharge?

2d. Does status at discharge after a span of home care have a stronger association with amount of service used, or with characteristics at entry?

Another series of questions was based on a finding among nursing home patients that those who had participated in the decision to utilize that service were significantly more satisfied with their situation than other patients (Day, 1972). Referral source was expected to vary more by pay plan than by personal characteristics, with lower likelihood of self-referral among those with high indicators of social, economic, and physical dependency. Among relatively short-term clients, physician referral was expected to be associated with higher intensity service use and higher likelihood of death or discharge to institutional care than other types of referral. Those referred by self or family were expected to decrease service use over the short-term. Referral was not expected to be significant to services used over a long duration. These referral questions are not presented in the detail of Hypotheses 1 and 2 because analysis of a previously gathered set of case records did not permit the expected scrutiny of referral source influence; entries concerning referral were considered too unreliable for testing these hypotheses. The distribution of referral sources is included, however, in the analyses which follow.

We turn now to discussion of how the research questions are addressed using a set of case records which represent the universe of cases served by the San Francisco Home Health Services, Inc. from mid-1957 through 1975. First, the specification of variables for analyzing utilization will be developed (Part II). Then the case files and the development of the set of cases for analysis will be described (Part III) along with the profile of entry characteristics and discharge status profiles. Discussion of relationships (Part IV) moves from two-way associations toward case-mix distinctions. Interpretations of the findings are reserved for Part V.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

February 1, 1982
Rec'd. 2/4/82

cc: Oscar Friedensohn
Olga Canal
Elliot Stern
Mary Guthrie
Carol Murpy
Liane Palacio, HRS

TO : Complex Model State/Site Directors

THROUGH: Mary Harahan

FROM : Bruce Spitz
Brina Melemed

SUBJECT: Issue Papers

The attached issue paper presents a summary of our understanding of how the complex model will function in your state and issues that need to be resolved. The paper summarizes the proposals and issues that have been discussed during our conference calls of the last month or so. We have placed primary emphasis on the budget development and reimbursement aspects of the project. Problems with respect to the implementation of core channeling functions will be addressed separately.

It is crucial that all of these issues be resolved as soon as possible if we hope to meet a reasonable time table for implementation. We assume that most of these will be addressed in your Task 3 Addendum.

Issues which remain after our review of your submission will constitute the agenda for a series of site visits to be conducted during the later part of February.

If you take exception to the attached description and critique, your comments should be submitted to us in writing within one week of receipt of the issue paper.

cc: Program Management Team
Project Officers
MPR
Temple

MIAMI JEWISH HOME AND HOSPITAL FOR THE AGED
MIAMI, FLORIDA

Florida has proposed a complex model project in Miami that provides a service pool made up of Title XVIII (40%), Title XIX (45%) and Title III and other state funds from the Community Care for the Elderly program (15%). The services pool will be used without regard to funding source. A post accounting process is anticipated to allocate authorized service costs back to the appropriate source.

The Miami site proposes to use the state Medicaid fiscal intermediary, System Development Corporation (SDC), as the payment mechanism for the project. SDC will hold all the pooled funds. The site will use a voucher system whereby services are authorized and paid under fixed rate contracts. Upon receipt of an appropriate provider invoice and approval by the site, the claim will be forwarded to SDC for payment. 1115 Medicaid waivers of amount, duration and scope provisions of the state Medicaid plan will permit the state to reimburse for all core services delivered to MA eligibles.

The proposal to create a services pool and consolidated payment mechanism is encouraged by DHHS. However, several issues need to be resolved and clarified before these can be implemented. We do not fully understand how the process for approving and reimbursing claims will actually take place. Since the state proposes to use SDC as the payment agent, we need to understand the implications of this approach on overall administrative time and costs. In addition, we need to understand how the Financial Control System currently being developed for the site as part of the demonstration will interface with the SDC system. We need to understand why the process being proposed is the most effective and efficient one, and whether significant delays in processing claims can be avoided. The means by which SDC in Tallahassee and MJHHA in Miami will communicate with each other and the nature of the information provided need to be clarified. The specific role of SDC solely as a claim processor is also unclear to us. The role of the site in decision-making and budget control and the role of the state in monitoring need to be clarified. Before we can approve your proposal to use SDC we need to clearly understand how it will work within the research and program principles of the demonstration and why it is a reasonable choice for the project and state.

It is our understanding that no state matching funds (Titles XIX and III) can be released until notice of award from HCFA. It is also our understanding that a delay of six to eight weeks might be anticipated before funds could actually be transferred. We understand that you are in the process of notifying us of this problem and promise a quick response to your letter. A delay of this extent could put the project start date off until June or later. This is unacceptable to us.

We also need to understand how current restrictions on the transmission and expenditure of Title III funds will be handled under the pooled funding arrangements. This is particularly significant given the large contribution from Title III. Where cost sharing is required, how do you propose to address the issue that no charges are permitted for Title III services? Will the post accounting process be sufficient? What controls will be put in place to assure that cost sharing not be used as part of a primarily Title III funded plan of care?

* The use of fixed rate contracts has been proposed. This proposal needs to be clarified. Which services will be bid? You have also discussed the use of negotiated group contracts for certain services. What is your current thinking on this subject?

* Site response is needed.

CASELOAD CHARACTERISTICS

The catchment area for Florida's Channeling Demonstration Project was selected as a result of its high concentration of elderly residents, diversity of ethnic/racial characteristics and spectrum of socio-economic levels. The target area encompasses the urban geographic areas of:

1. The City of Miami
2. Mental Health Catchment Area V which includes the municipalities of Miami Beach, Bay Harbor Island, Bal Harbour, North Bay Village and Surfside.

The population age 65 and over in the target area represents forty-two percent (42%) of the entire over 65 population in Dade County. Thus there are approximately 115,000 persons over age 65 in Channeling's service area. Of this subgroup thirty-eight percent (38%) are defined as low income. In Dade County as a whole those persons aged 75 and over represent six percent (6%) of the total population. Thus a similar distribution projected for the target area which also accounts for the fact that the over age 75 population in Catchment Area V represents seventeen percent (17%) of the total population, indicates that there are approximately 44,000 persons over age 75 in Channeling's service area.

Of the 115,000 elderly persons in the target area, it is estimated that 6.9% of them, or 7,900 individuals will meet Channeling's eligibility criteria. This estimate is based on two data sources. Lawrence Branch's monograph on the vulnerable elderly estimates that seven percent (7%) of the over age 65 population has two or more impairments in activities of daily living. Unpublished data from the 1977 National Health Interview Survey indicates that 6.9% of the over 65 noninstitutionalized population are chronically ill and are dependent in two or more activities of daily living. The 450 clients in the Channeling Demonstration Project will be drawn from the 7,900 individuals in the target area who meet the eligibility criteria.

Most of Dade County's elderly residents are Medicare eligible but there are a significant number of hispanic elderly who have not met the five year residency requirement and are not covered by Medicare. Applying the percentages of Dade County's population covered by Medicare and Medicaid, it is estimated that Channeling's clients will have the following coverage:

CASELOAD CHARACTERISTICS BY MEDICARE
& MEDICAID COVERAGE

COVERAGE		NUMBER OF CHANNELING CLIENTS
Medicare Parts A & B	(81%)	365
Medicare Part A	(75%)	338
Medicare Part B	(80%)	360
Medicaid only	(16%)	72
Medicaid/Medicare	(3%)	14

For purposes of characterizing the projected Channeling caseload and their service needs, demographics from other community-based service programs serving a similar geographic area and target population may be useful in highlighting local trends. During 1981 the community service programs of Channeling's parent agency, the Miami Jewish Home and Hospital for the Aged, served 7,125 clients; 2,000 clients per month; 17% minorities (Hispanic/Black); and, 68% female. These figures are for concrete service provision and exclude information and referral, services to client collaterals, and community/continuing education.

The two adult-day care programs served 305 unduplicated clients averaging 2.5 days of service per week. The average age of the clients was 81.

During January to December, 1981, the Douglas Gardens Community Mental Health Center, which serves the Miami Beach portion of Channeling's target area, served over 1,000 active clients, 25% of whom received services in the Geriatric Unit. Relevant demographics of the geriatric clients include:

-73% female;

-89% Anglo and 10% Hispanic;

-41% widowed;

-51% were ineligible for Title XX;

-4% were Cuban Refugees (individuals not covered by Medicare Part A).

-59% reside in the South Miami Beach area;

-The major primary diagnosis at the time of admission was depressive/affective disorder. For 7% of the geriatric clients the diagnosis was organic brain syndrome (OBS).

The Ambulatory Health Services of the Miami Jewish Home and Hospital for the Aged delivers primary medical care to Medicare eligible persons aged 65 years and older, living independently in the community, without a private physician. During January-December 1980, 588 persons were active Ambulatory Health Service clients. The reported place of residence of individuals utilizing services corresponds to the Channeling Project target area for approximately 80% of the clients. Characteristics of AHS clients are as follows:

-70% were female;

-The age range was 60 to 94, with an average of 78 years of age;

-18% were 85 years of age and over;

-52% widowed;

-46% live alone;

-70% reported an annual income under $5,000.

-71% required transportation from an outside provider;

-Clients averaged four clinic visits for the year;

-43% of the clients had five significant diagnoses at the time of intake;

-25% were regularly taking four or more medications at intake;

-The annual attrition rate was 7% with a distribution of 4% deceased, 2% relocated and 1% institutionalized.

In the monograph entitled Vulnerable Elders, Lawrence Branch, Ph.D. of Harvard Medical School, addressed the difficult problem of identifying the "at risk" elderly population who will enter nursing homes if community care is not provided. Based on a sample of 1,625 noninstitutionalized elderly aged 65 or over, "vulnerable" elderly were found to reflect the following characteristics:. female, widowed or never married; 75 or older, and having a lower income than their peers. Clients of the programs briefly discussed resemble Branch's vulnerable elderly.

Factors such as the growing proportion of elderly in our community, the increasing "old-old" population segment, rising medical care costs, fixed incomes and social services cutbacks will increase the individuals at risk of nursing home placement. Although statistically significant conclusions are not provided by the "client portrait" presented, a rationale inference is that Channeling clients will be vulnerable elderly. As such, their needs and profile differ significantly from the national statistics on the 65 and over population and from programs which focus on service delivery to a well-elderly population.

PROJECTED PROGRAM SERVICE BUDGET

Based on the anticipated characteristics of the Channeling caseload, projections have been formulated regarding utilization patterns for the core services (see Chart #1 for core service definitions). To estimate how many Channeling clients will need each of the core services, projections were made based on the experiences of the Wisconsin Community Care Organization, the Triage Project, Section 222 day care and homemaker experiments and MJHHA community service programs (Chart #2).

Charts #3 and 4 depict the number of Channeling clients needing each core service and the anticipated units of service needed by each client. Year One covers the initial service delivery period through September 30, 1982. Year Two covers the first full year of service delivery, October 1, 1982 through September 30, 1983. The unit cost estimates are subject to revision based on negotiations with potential service providers.

Finally, Chart #5 shows the proportions of the program service budget to be allocated to the major subjsets of the core services.

Chart #1

CHANNELING DEMONSTRATION PROGRAM
CORE SERVICE DEFINITIONS

SERVICE	DEFINITION	UNIT
Day Health & Rehab. Care	Comprehensive therapeutic, rehabilitative, supportive health care and activities provided to functionally impaired adults in a protective setting for a portion of a 24 hour day. Includes nursing services, rehabilitation, assistance with activities of daily living, at least one meal per day, social work services, and transportation.	1 client day
Day Maintenance Care	Comprehensive supportive services provided to functionally impaired adults in a protective setting for a portion of a 24 hour day. Includes all the above listed services with the exception of nursing and personal care services.	1 client day
Home Health Aide	Personal care provided under the supervision of an appropriate health professional. Includes assistance with activities of daily living, assistance with administering medication, meal preparation, and light household tasks.	1 client hour
Homemaker	Household tasks provided by professionally supervised and trained homemakers. Includes light cleaning, shopping, laundry, assistance with grooming, dressing, transfer activities, meal preparation, and limited escort service to accompany client to medical appointments.	1 client hour
Housekeeping	Provision of cleaning tasks, shopping, laundry and meal preparation.	1 client hour
Chore	Heavy housecleaning and minor home repairs. Includes seasonal cleaning, pest control and yard work.	1 client hour
Companionship	Visiting isolated clients to relieve loneliness and provide social stimulation. Includes conversation, reading, letter writing, errands.	1 client hour

SERVICE	DEFINITION	UNIT
Home Delivered Meals	Provision of nutritionally sound meals which meet one-third of the recommended dietary allowances.	1 meal
Respite Care	Provision of twenty-four hour care to allow temporary relief to primary caregivers. Care is limited to two weeks and may be provided in the client's home, a foster or adult care home, or a nursing home.	1 twenty-four hour day
Skilled Nursing Services	Nursing services provided in a client's home or an ambulatory care setting.	1 client hour
Physical Therapy	Rehabilitative therapy provided by a qualified physical therapist.	1 client treatment
Speech Therapy	Corrective speech therapy provided by a qualified speech therapist.	1 client session
Occupational Therapy	Restorative therapy provided by a qualified occupational therapist.	1 client session
Mental Health	Provision of diagnostic and therapeutic mental health services by a qualified clinical psychologist or social worker. Includes group and individual counseling.	1 client hour
Transportation	Travel to or from service providers or community resources. Includes regular automobiles in addition to specially equipped vehicles for nonambulatory clients.	1 client one-way trip
Escort	Personal accompaniment to or from service providers and personal assistance as needed.	1 client round trip
Housing Assistance	Search for suitable housing and arrangements to physically move the client's belongings. Could also include emergency shelter for a period not to exceed seven days.	1 physical move or 1 day of emergency shelter
Adult Foster Care	Placement in a certified adult foster home.	1 client day

Chart #2

CHANNELING DEMONSTRATION PROJECT
PROJECTED SERVICE UTILIZATION

Percent of Clients Using and/or Needing Services

SERVICE	WISCONSIN PROJECT +Vulnerable Elderly +Sect. 222 Experiments	TRIAGE PROJECT	PROJECTED FOR CHANNELING
Rehab. Day Care	7%	-	7%
Day care	25	-	21
Home Health Aide	28	36%	32
Homemaker	33	19	15
Housekeeping	20	-	25
Chore	-	25	35
Companion	-	4	15
Meals	10	24	10
Respite	10	-	10
Skilled Nursing	40	47	40
Phys. Therapy	-	4	5
Speech Therapy	-	-	2
Occupational Therapy	-	-	2
Mental Health	25	-	25
Transportation	57	-	57
Escort	-	-	15
Housing Assistance	-	-	5
Foster Care	-	-	5

Chart #3

YEAR ONE
(based on 220 clients monthly average)

CHANNELING DEMONSTRATION PROJECT
PROJECTED PROGRAM SERVICE BUDGET

CORE SERVICES	# of CLIENTS	AVERAGE UNITS/CLIENT FOR 5 MOS.	UNIT COST	TOTAL COST
Rehab. Day Care	15	50 days	40	$ 30,000
Day Care	46	56 days	30	77,280
H.H. Aide	70	130 hours	10	91,000
Homemaker	33	175 hours	8	46,200
Housekeeping	55	110 hours	7	42,350
Chore	77	20 hours	8	12,320
Companion	33	130 hours	5	21,450
Meals	22	150 meals	3.50	11,550
Respite	22	2 weeks	750	16,500
Skilled Nursing	88	10 hours	22	19,360
Phys. Therapy	11	16 visits	50	8,800
Speech Therapy	4	16 visits	50	3,200
Occup. Therapy	4	16 visits	50	3,200
Mental Health	55	20 hours	60	66,000
Transportation	125	65 round trips	18	146,250
Escort	45	40 trips	8	14,400
Housing Assist.	11	1 move	450	4,950
Foster Home	11	5 months	400	22,000
			TOTAL SERVICE BUDGET	$636,810

Revised 1/22/82

Chart #4

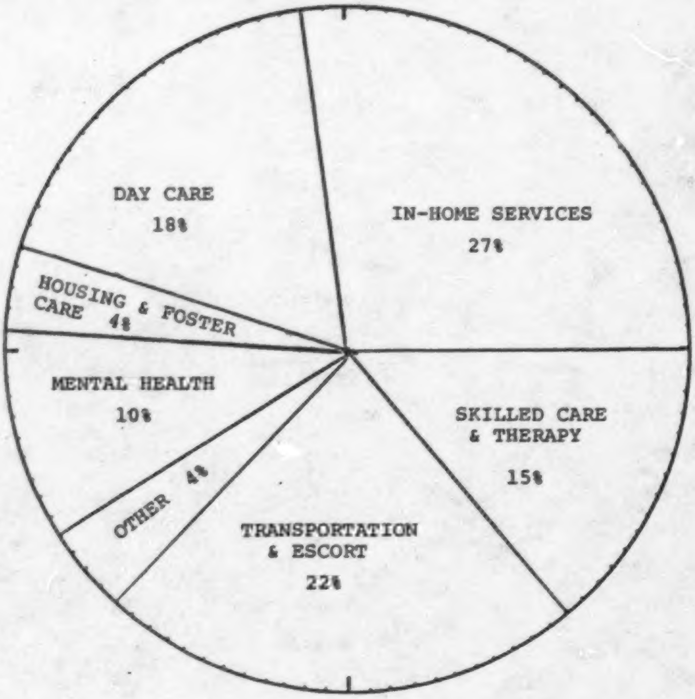
CHANNELING DEMONSTRATION PROJECT
PROJECTED PROGRAM SERVICE BUDGET

CORE SERVICES	# of CLIENTS	AVERAGE UNITS/CLIENT PER YEAR	UNIT COST	TOTAL COST
Rehab. Day Care	30	115 days	40	$ 138,000
Day Care	95	140 days	30	399,000
H.H. Aide	144	312 hours	10	449,280
Homemaker	68	416 hours	8	226,304
Housekeeping	113	260 hours	7	205,660
Chore	160	42 hours	8	53,760
Companion	68	312 hours	5	106,080
Meals	45	365 meals	3.50	57,488
Respite	45	2 weeks	750	33,750
Skilled Nursing	202	100 hours	22	444,400
Phys. Therapy	23	40 visits	50	46,000
Speech Therapy	9	40 visits	50	18,000
Occup. Therapy	9	40 visits	50	18,000
Mental Health	112	52 hours	60	349,440
Transportation	256	156 round trips	18	718,848
Escort	66	80 trips	8	42,240
Housing Asst.	23	1 move	450	10,350
Foster Home	23	12 months	400	110,400
		TOTAL SERVICE BUDGET		$3,427,000

Revised 1/22/82

Chart #5

CHANNELING DEMONSTRATION PROJECT
ALLOCATION OF PROGRAM SERVICE BUDGET BY CORE SERVICES



©MINNESOTA MINING AND MANUFACTURING COMPANY 1978 PIE CHART 5-3/8"

NATIONAL LONG-TERM CARE DEMONSTRATION PROJECT

Federal Level

Department of Health and Human Services

Administration on Aging

Assistant Secretary for Planning & Evaluation

Health Care Financing Administration

Mathematica Policy and Research (research/eval. contract)

Temple University Institute on Aging (tech. assistance contract)

States

Complex Models
- Philadelphia, Pa.
- Rensselear County, N.Y.
- Lynn, Ma.
- Cleveland, Ohio
- Miami, Florida

Basic Models
- Houston, Tx.
- Hazard, Ky.
- New Brunswick, N.J.
- Portland, Me.
- Baltimore, Md.

State Level

State of Florida
Dept. of Health & Rehabilitative Service

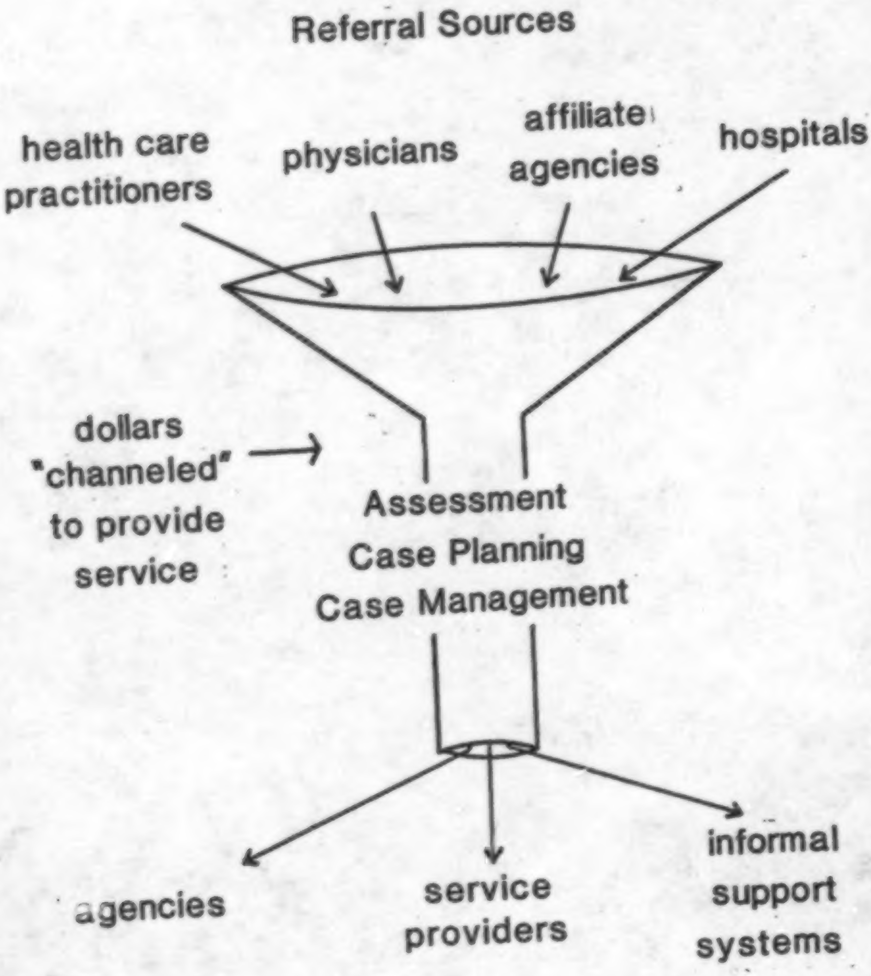
Aging and Adult Services Program Office
State Channeling Project Director
Program Specialist

Site Level

District XI, Aging & Adult Services Program Office

Miami Jewish Home and Hospital for the Aged
Channeling Project

Channeling Service


Referral Sources
health care practitioners
physicians
affiliated agencies
hospitals
dollars "channeled" to provide service
Assessment
Case Planning
Case Management
agencies
service providers
informal support systems

Chairman SIMPSON. Mr. Westall, please.

Mr. WESTALL. Mr. Chairman, I'm delighted to be here today. I appreciate your invitation.

I hope that I reflect the field operation of Department of Medicine and Surgery and more particularly my experiences as director of the Bay Pines Medical Center.

I would like to summarize my written testimony with the request that you include that testimony in the records——

Chairman SIMPSON. Without objection.

Mr. WESTALL. Because that testimony underscores many points that were made by the witnesses thus far.

I am in total agreement with the position that Dr. Custis has taken with several exceptions.

One is the shifting population which the sunbelt is experiencing. In Florida we have evidenced that by some statistics quoted in the written testimony and certainly in the field operation at Bay Pines, I think all the hospitals in the State of Florida reflect what the agency will face in dealing with the aged veteran 10 years from now.

I would like to underscore very strongly the hospital based home care program and expansion of that type of care and with more involvement of the community and the family in the direct care of veterans who are beneficiaries of the Veterans' Administration.

I have seen the hospital-based home-care program in two different medical facilities and it's an excellent example how we can extend our treatment and at the some time bring a very compassionate family relationship into that direct care.

I think it's unfortunate that the Department of Medicine and Surgery and the Department of Veterans' Benefits don't work closer and have better communication in relationship to the total veterans' benefits program.

I cite an example of our domiciliary experience at Bay Pines where we outplaced about half of the population, from about 350 to roughly 170; and that took place only after a considerable amount of screening, both medical, psychological and social.

Three of those veterans had to return because they were caught in a "Catch 22" situation of losing financial benefits. The benefit that I refer to, is that they were receiving 20-percent service-connected disability and that had been increased to 100 percent while they were in a very sheltered domiciliary environment.

After a great effort on the staff to outplace these people, DVB removed their financial benefits which necessitated their readmission to the domiciliary. That's a legal requirement for DBV to do that. But it terminated the independence of these individuals from the VA health care system.

I think a compassionate and coordinated approach by both departments of the VA would allow individuals in similar situations to establish an independent living environment.

It's unfortunate that Dorothy Starbuck is not present today. As DVB can play a major role in improving out placements for the older veteran.

I would like to comment that I think, too, it's unfortunate you associated your question on the alcoholism with the VA domiciliary program.

To me that reflects a reputation of a drying out tank for every veteran who enters a domiciliary; and that really isn't true. I think it also reflects a history of an old soldier's home concept that has been associated with the domiciliary program for years.

Today's environment in the domiciliary deals with a quality of life dimension that takes in many considerations such as the lack of a caring family, lack of work abilities, restricted physical or mental requirements and social adjustments for community living.

I'm not here to support only the domiciliary program, but I think it is an important facet of the total VA medical care program and should be kept in proper perspective when considering distribution of resources.

I would be willing to answer any questions. I've highlighted this testimony and tried to remove some of the emotion that one must feel when dealing with it at a direct care level.

Chairman **Simpson**. Well, you didn't leave all the emotionalism out of it, just some of it.

No, I wouldn't want to indicate that, we're talking about drying out tanks or detox' centers, but I'm saying that it's a problem and we're going to look at it; and so we are.

How about that?

Mr. **Westall**. I think that's excellent.

May I comment on one other question raised with Dr. Haber.

Chairman **Simpson**. Yes.

Mr. **Westall**. The question of percentage of service-connected veterans versus non-service-connected veterans in community nursing home care.

Chairman **Simpson**. Right.

Mr. **Westall**. The percentage of service-connected veterans reflects a concession to families to have their member in closer proximity to their home. Many of our VA facilities are isolated or far removed in mileage from the consumers. When we do outplace service-connected veterans to community nursing homes it certainly has been my experience, that many of those if not most are done in association with requests from the families.

Chairman **Simpson**. Indeed, that is true about the geographic locations of facilities.

I might ask you with regard to what you did as the director of the Bay Pines facility. What happened when that GRECC went out of existence? Did that impact on the care of aging veterans at the Bay Pines Medical Center?

Mr. **Westall**. I'm sorry, I wasn't the director of Bay Pines when that was removed.

Chairman **Simpson**. No, I know that.

Mr. **Westall**. But I do think it's unfortunate that the new requirements for GRECC require an affiliation with a medical school as part of the criteria. That automatically eliminates a facility like Bay Pines which, I think, has the greatest population for research in aging.

What it does mean is that hopefully Tampa in affiliation with the University of South Florida Medical School will end up getting a GRECC and we can piggyback on that GRECC program for research and education purposes.

Chairman SIMPSON. Is Bay Pines a center that is close to its service population?

Mr. WESTALL. Yes, it is.

Primarily, we serve Pinellas County. By the way, that county has an average of about 32 percent of the population that is over 65 as compared to 18 percent nationally.

[The prepared statement of Jack S. Westall, former Director, Veterans' Administration, and his response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, and the response of Donald L. Custis, M.D., Chief Medical Director, Veterans' Administration, to the written questions submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, relating to the testimony of Jack S. Westall, former director, Veterans' Administration Medical Center, Bay Pines, Fla., follow:]

PREPARED STATEMENT OF JACK S. WESTALL, FORMER DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, BAY PINES, FLA.

MR. CHAIRMAN, I WELCOME THIS OPPORTUNITY TO APPEAR BEFORE YOUR COMMITTEE TODAY AND SHARE MY EXPERIENCES AND SUGGESTIONS WITH YOU. MY COMMENTS, AS WELL AS MY RESPONSES TO YOUR QUESTIONS, WILL REFLECT MY CAREER WITH THE VETERANS ADMINISTRATION. MORE THAN TWENTY-TWO YEARS WERE IN SIX DIFFERENT HOSPITALS, AND SOME THIRTEEN YEARS IN CENTRAL OFFICE IN VARIOUS POSITIONS. I HAVE A STRONG LOYALTY TO THE AGENCY AND A DEEP RESPECT FOR THE TALENTED CAREER PEOPLE WHO MAKE THE SYSTEM FUNCTION SO WELL. I ACCEPTED YOUR INVITATION BECAUSE I, TOO, HAVE A CONCERN FOR HOW OUR COUNTRY IS GOING TO DEAL WITH AN AGING POPULATION. I FEEL THAT THE VA HAS THE ORGANIZATION AND KNOW-HOW AND WITH ADEQUATE RESOURCES CAN FULFILL ANY MANDATE OF CONGRESS REGARDING PROGRAMS FOR THE OLDER VETERAN.

THE CHALLENGE THIS COMMITTEE, AS WELL AS THE AGENCY HAS, IS TO OBTAIN REALISTIC DEMOGRAPHIC DATA CONCERNING VETERANS AND VETERANS HEALTH BENEFITS. FOR INSTANCE, WE READILY KNOW HOW MANY LIVING VETERANS THERE ARE AND WHAT AGE CATEGORIES THEY FALL INTO. HOWEVER, WHAT HAS NOT BEEN AVAILABLE, AT LEAST IN MY CAREER, WAS HARD DATA ON THE ACTUAL NUMBER OF VETERANS WHO USE THE VAST MEDICAL CARE SYSTEM. AS I REMEMBER, THE BEST GUESSTIMATE SOME SIX YEARS AGO, WAS OF THE LIVING 30 MILLION VETERANS APPROXIMATELY 6 MILLION WERE CONSUMERS OF VA HEALTH CARE SERVICES. THIS WOULD INDICATE THAT FOUR-FIFTHS OF THE VETERAN POPULATION DO NOT OR ARE NOT REGULAR USERS OF THE SYSTEM. THIS COULD BE FOR A NUMBER OF REASONS: ISOLATION FROM VA FACILITIES, DEPENDENCE OR PREFERENCE ON PRIVATE HEALTH INSURANCE OR OTHER COVERAGE SUCH AS MEDICARE.

NATIONAL PLANNING HAS TO TAKE INTO CONSIDERATION HOW THE SYSTEM COULD BE IMPACTED SHOULD THE CURRENT NON-USERS EXERCISE THEIR ELIGIBILITY DURING THEIR OLDER YEARS TO DEMAND CARE THEY'LL BE ENTITLED TO. FOR THOSE WHO REACH 65 AND ARE ENTITLED TO UNQUESTIONED ELIGIBILITY FOR CARE FOR THE FIRST TIME, IT COULD PLACE A TREMENDOUS IMPACT ON THE SYSTEM AND THE LIMITED RESOURCES IT HAS.

THE CHIEF MEDICAL DIRECTOR HAS INITIATED A CHANGE WHICH PLACES PLANNING AT THE MEDICAL DISTRICT LEVEL. WHILE I'M NOT TOTALLY FAMILIAR WITH THE CURRENT STATUS OF THAT ACTION, I AM ENCOURAGED THAT THE CONCEPT HAS THE POTENTIAL TO IMPROVE THE PLANNING AND RESULTING CHANGES IN PROVIDING HEALTH CARE FOR VETERANS. THIS OPERATIONAL CHANGE SHOULD FOCUS ON THE EXISTING FACILITIES AND RESOURCES AS VERSUS THE GEOGRAPHICAL DEMAND FOR SERVICES. IT SHOULD ALSO ALLOW FOR GREATER UTILIZATION OF COMMUNITY RESOURCES AND TALENT IN MEETING VETERANS' MEDICAL NEEDS.

I FULLY REALIZE THE POLITICAL IMPRACTICALITY OF MY MENTIONING IT BUT IN CONSIDERING NATIONAL PLANNING FOR VA SERVICES I AM COMPELLED TO DO SO. THERE MUST BE RECOGNITION GIVEN TO POPULATION SHIFTS OCCURRING IN OUR COUNTRY AND HOW THIS AFFECTS MEDICAL CARE PROVIDED TO VETERANS. OPERATIONAL LOGIC DICTATES THAT RESOURCES BE TRANSFERRED TO CORRESPOND TO THESE SHIFTS IN POPULATION. THIS BECOMES EVEN MORE MEANINGFUL WHEN YOU CONSIDER THAT THE SHIFT IS MOSTLY RETIRED PERSONS. AT LEAST THIS IS TRUE IN THE STATE OF FLORIDA AND THE BAY PINES MEDICAL CENTER. IT IS SAID THAT MORE THAN 5,000 VETERANS MOVE TO FLORIDA A MONTH WITH THE MAJORITY SETTLING IN THE TAMPA BAY AREA. IN PINELLAS COUNTY (ST. PETERSBURG-CLEARWATER AREA OF TAMPA BAY) WHERE BAY PINES IS LOCATED, THE PERCENTAGE OF THE POPULATION OVER AGE 65 IS 32%. THIS COMPARES TO A NATIONWIDE PERCENTAGE OF 18% AND A FLORIDA-WIDE

PERCENTAGE OF 23%. THE PROBLEM IS BEYOND THE DISCUSSION STAGE IN FLORIDA--IT'S A REALITY THAT THE VA FACILITIES ARE TRYING TO COPE WITH ON A DAILY BASIS.

THE IMBALANCE IN RESOURCES AND POPULATION REQUIRES THAT VETERANS USING VA HEALTH CARE SERVICES ARE TREATED DIFFERENTLY THROUGHOUT THE COUNTRY. IN AREAS WHERE THE DEMAND IS GREATEST, THE MEDICAL AND ADMINISTRATIVE SCREENING IS STRICTER. MANY VETERANS WINTERING IN FLORIDA CANNOT RECEIVE THE SAME DEGREE OF CARE AS THEY GET DURING THE SUMMER MONTHS IN THEIR NORTHERN STATES. THOSE ADMITTED TO A HOSPITAL BED IN FLORIDA VA FACILITIES EXPERIENCE A SHORTER LENGTH OF STAY THAN THE NATIONAL AVERAGE AND THIS TAKES INTO CONSIDERATION ALL MEDICAL SPECIALTIES.

I WOULD SUGGEST THAT THE WAY OF THE FUTURE IS FOR VA TO INCLUDE AND ENCOURAGE A GREATER ROLE OF THE VETERAN'S FAMILY AND COMMUNITY IN HIS HEALTH CARE. THE HOSPITAL (BEDS) CATEGORY OF CARE MUST BE RESERVED FOR THE MOST CRITICALLY NEEDED MEDICAL CARE. OUTPATIENT PROGRAMS MUST BE EXPANDED WITH THE GOAL OF TERMINATING DEPENDENCE ON THE VA AS EARLY AS POSSIBLE.

THE EXISTING HOSPITAL BASED HOME CARE (HBHC) PROGRAM IS A GOOD REFERENCE OF DIRECT FAMILY INVOLVEMENT. IT SERVES BOTH THE VETERAN AND THE VA IN A NUMBER OF WAYS. IT FREES THE HOSPITAL BED FOR MORE ACUTE CARE NEEDS; IT ALLOWS FOR A GREATER NUMBER OF VETERANS TO BE CARED FOR BECAUSE OF A MORE ECONOMICAL METHOD FOR VA. BUT EVEN IMPORTANT, IT ALLOWS THE FAMILY TO CONTRIBUTE TO THE DIRECT CARE OF THE VETERAN. TO WITNESS THE MARVELOUS CARE THE VETERAN RECEIVES FROM A DEVOTED FAMILY MEMBER MAKES ONE REALIZE THAT IT IS BEST FOR ALL CONCERNED WHEN SUCH CARE CAN BE PROVIDED IN A HOME ENVIRONMENT. VA SHOULD EXPLORE WAYS THAT THE AGENCY COULD FURTHER

ASSIST AND ENCOURAGE FAMILY INVOLVEMENT. THIS MIGHT INCLUDE: FULLY EQUIPPED MOBILE UNITS TO VISIT HOMES, LIMITED HEALTH CARE FOR A SPOUSE WHO IS CARING FOR A VETERAN, ASSURED RELIEF WHEN FAMILY NEEDS A BREAK IN DIRECT CARE FUNCTIONS. OBVIOUSLY, HBHC ISN'T THE TOTAL ANSWER BUT IT COULD PLAY A LARGER ROLE IN MEETING EVER EXPANDING DEMANDS FOR MEDICAL CARE.

ALL THE RESOURCES OF THE COMMUNITY, BOTH MEDICAL AND SOCIAL, SHOULD BE UTILIZED WHENEVER POSSIBLE IN EXTENDING HEALTH SERVICES TO VETERANS. THIS IS CRITICAL IN ENCOURAGING A VETERAN TO RE-ESTABLISH AN INDEPENDENT LIFE-STYLE AFTER LONG PERIODS OF INSTITUTIONAL CARE BY THE VA.

I AM CONVINCED THAT IMPROVED SERVICES TO VETERANS WOULD ALSO RESULT FROM A CLOSER WORKING RELATIONSHIP BETWEEN THE DEPARTMENT OF VETERANS BENEFITS AND THE DEPARTMENT OF MEDICINE AND SURGERY. THIS IS PARTICULARLY TRUE WHERE VETERANS ARE RECEIVING FINANCIAL BENEFITS AND ROUTINELY USE THE MEDICAL FACILITIES FOR HEALTH CARE. VETERANS ARE OFTEN CAUGHT ON A "CATCH 22" SITUATION OF LOSING FINANCIAL SUPPORT AT A TIME OF GREATEST NEED BECAUSE OF ADJUDICATION RESTRAINTS. THIS IS ILLUSTRATED BY A RECENT EXPERIENCE AT BAY PINES. OF THE 175 TO 200 OUTPLACEMENTS FROM THE DOMICILIARY PROGRAM, THREE MALE VETERANS WERE READMITTED AFTER SUCCESSFULLY ESTABLISHING INDEPENDENT LIVING IN THE COMMUNITY BECAUSE IT WAS DETERMINED THAT DISABILITY PAYMENTS WERE NO LONGER LEGALLY APPLICABLE. IN THESE CASES, THE ONLY WAY THESE INDIVIDUALS COULD MAINTAIN THEMSELVES AND BE FREE OF INSTITUTIONAL CARE WAS TO CONTINUE TO RECEIVE VA FINANCIAL SUPPORT. ONE OF THESE INDIVIDUALS WAS CONSIDERED TO BE "TOTALLY INSTITUTIONALIZED" BEFORE THE VA MEDICAL TEAM MADE A REMARKABLE TRANSITION IN HIS LIFE WITH A SUCCESSFUL OUTPLACEMENT.

IMPROVED COMMUNICATION AND UNDERSTANDING OF MUTUAL SERVICES IS NECESSARY BETWEEN THE TWO MAJOR DEPARTMENTS OF THE AGENCY IN ORDER TO APPRECIATE THE IMPACT OF ONE FACET OF THE SYSTEM ON ANOTHER AS AFFECTS AN INDIVIDUAL VETERAN.

I'M AWARE THAT I HAVE ONLY TOUCHED ON SOME OF YOUR AREAS OF CONCERN. I WILL BE PLEASED TO RESPOND TO ANY QUESTIONS YOU MAY HAVE RELATING TO MY TESTIMONY.

RESPONSE OF JACK S. WESTALL, FORMER DIRECTOR OF THE VETERANS' ADMINISTRATION MEDICAL CENTER, BAY PINES, FLA., AND FORMER ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION OF THE VETERANS' ADMINISTRATION, WASHINGTON, D.C., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. Would you change or re-direct the VA's program that treats its aging veterans? If so, how?

Answer 1. Every VA medical bed program should be considered a "transitional" period in a veteran's life. Unfortunately for some, a VA facility is the final destiny that the individual, the family and in some cases, the staff has accepted. For those with a catastrophic or terminal illness VA provides as talented and compassionate care as can be found anywhere. While it's true that many cannot be released because of the seriousness of their illness, an outplacement to the veterans homes or community should always be the goal. Discharge planning must begin at the point of admission to the health care facility and continue until all possibilities are exhausted for outplacement. VA must continue to work with patients and member families and with community resources to encourage early outplacement.

While the above comments would pertain to veterans of all ages, the problems of outplacing older veterans are more complicated for many reasons. The challenge is therefore more difficult.

Question 2. What barriers do you believe exist in the VA health-care system which may prevent the "de-institutionalization" of its aging population?

Answer 2. I don't believe there are any real "barriers" to prevent "de-institutionalization". There is a variety of influances on facility management which allow institutionalization patterns to develop. They include a number of diverse factors which are both national and local in score, but none that cannot be overcome through effective management at the facility level.

Question 3. Are community-based programs, which provide health and social support services to the elderly, available throughout the Nation?

Answer 3. I believe that you would find such support agencies in most metropolition areas. I feel certain that such support would vary greatly on State and local community levels. What might be available in one VA Medical Center catchment area would not necessarily be available in others. I don't believe that a national policy for the VA could be developed which would depend on such local support.

Question 4. Are these programs standard? Do they vary in quality and quantity?

Answer 4. Very greatly.

Question 5. Do you have any suggestions that would help the VA Department of Medicine and Surgery and the VA Department of Veterans' Benefits better coordinate the available health-care and other VA benefits for eligible aging veterans?

Answer 5. There is a need to more personalize the adjudication process for financial benefits in order to allow some veterans to break the total dependence on the health care system for a "decent" standard of living. Service-connected compensation is increased to 100% if hospitalized or domiciled 21 days or longer. When outplaced, and often at the most crucial period in their adjustment to independent living, these financial benefits are reduced or terminated. This frequently disrupts the entire outplacement process and requires reentry of the veteran into a VA "bed" program or a concentrated effort to involve community support which may or may not be available.

For those veterans who have spent much of their adult life in the sheltered environment of VA facilities and developed a dependency on VA, the fears associated with cutting "ties" can be devastating. Losing financial support at a time when it's needed most adds a difficult demension to the outplacement sequence.

I would suggest that problem be reviewed by DVB and DM&S at the national level with the goal of allowing some flexibility in the adjudication timetables. Once the proper climate is set to announce a policy change, the concerned field officers can effectively work out the details on an individual case basis. It would be important to incorporate DM&S field personnel familiar with a particular case to participate in the adjudication decision made by the Regional Office having jurisdiction.

Termination or extension of financial benefits would correspond with the actual adjustment progress rather than an unrealistic mandatory period as determined by the "book".

Question 6. Would you comment on the effectiveness of the present role of the VA GRECCs in the agency's overall program of providing health care to eligible veterans? Please address each of the three program areas of geriatric care, i.e., research, education, and clinical activities.

Answer 6. I've never had direct association with a GRECC at the field station level. However, from my Central Office experience and discussions with colleagues with participation in GRECC programs, the following comments reflect the principal weakness:

o Too great of a dependence on one individual to carry the GRECC. If the individual left the program, the GRECC could not successfully carry on.

o Weak leadership at the GRECC level.

o GRECC received low priority for research funding. Field proposals for research in aging support at the national level could not compete with the more glamorous medical and surgical projects.

o Attention to the aging problem has been an on again-off again situation for too many years. The lack of quality continuity to the effort has caused the GRECC program to suffer by comparision with other medical programs.

Education in the field of geriatric care seems to have been the best result of GRECC to date. There have been some effective interchanges of experiences and data.

RESPONSE OF DONALD L. CUSTIS, M.D., CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, TO THE WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS, RELATING TO THE TESTIMONY OF JACK S. WESTALL, FORMER DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, BAY PINES, FLA.

Mr. Westall, in his testimony, cited an example of efforts to outplace Bay Pines VAMC domiciliary residents to illustrate the need for closer working relationships between the Department of Medicine and Surgery and the Department of Veterans' Benefits. He stated:

> Three of these [domiciliary residents] had to return [to the domiciliary] because they were caught in a "Catch 22" situation of losing benefits. That benefit that I refer to is that they were in the area of 20 percent service-connected disability and that had been increased to 100 percent while they were in a very sheltered domiciliary environment.
>
> After a great effort [by] the staff to outplace these people, DVB removed their benefits. Now that's a legal requirement for DVB to do that.

It appears that Mr. Westall was referring to the increase to a total disability rating that a service-connected veteran receives after 21 days of hospitalization. However, according to VA regulations (38 CFR, sections 4.29 and 4.30), this increased rating is given only to a veteran requiring certain hospital observation or treatment for a period in excess of 21 days for a service-connected disability or convalescence following certain hospital treatment for such a disability.

A. Do domiciliary residents fall into either of these categories, and thus qualify for total disability compensation?

B. [If not] How else can the situation Mr. Westall outlined be explained?

Department of Medicine and Surgery
Washington D.C. 20420

Veterans Administration

OCT 25 1982

In Reply Refer To: 136F

Honorable Alan Cranston
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

Your letter of August 18, 1982, requested clarification of testimony given by Mr. Jack S. Westall before the Committee on June 30, 1982. Specifically, you asked if domiciliary patients were awarded temporary total disability ratings on the basis of 38 CFR 4.29 and 4.30.

In checking with the staff at the Veterans Administration Medical Center at Bay Pines, Florida, on the examples Mr. Westall gave in his testimony, there was one veteran who was hospitalized for his service-connected disability and required a protracted period of convalescence. During that convalescence, he was transferred to the domiciliary and subsequently outplaced to an independent living residence. On termination of his convalescent period, the veteran's VA monetary benefits were reduced to the monetary award commensurate with his service-connected rating. The veteran lacked adequate financial resources to continue in the independent living residence and was accepted back in the domiciliary. In other situations, veterans in receipt of VA pensions obtain modest or part-time jobs to supplement their income which then gives them adequate financial resources to live in the community. If their earned income exceeds the VA pension maximum income level, the pension is terminated or, if they lose their jobs, the pension alone is inadequate to maintain an independent residence. These veterans, with pensions as their sole income, cannot financially afford to live in an independent residence and request return to the domiciliary.

Domiciliary residence, in and of itself, would not qualify a veteran for the temporary total evaluation under either 38 CFR 4.29 or 4.30. Treatment or observation in a VA hospital for a period in excess of 21 days is required for consideration under 38 CFR 4.29. This temporary total evaluation may be extended for one or more months following discharge if a period of convalescence is required. Surgery necessitating posthospital convalescence, severe postoperative residuals or immobilization of a major joint by cast, without surgery, is required for consideration under 38 CFR 4.30. A temporary total evaluation based on a need for convalescence would be in order whether the veteran is convalescing in a VA domiciliary or in his or her own home.

We hope this information will clarify our implementation of the provisions of 38 CFR 4.29 and 4.30.

Sincerely,

DONALD L. CUSTIS, M.D.
Chief Medical Director

Chairman Simpson: Let me just ask Dr. Brody——

Of course you three are familiar with this case management model, I believe. You indicate some knowledge of that.

I would ask you to comment on the present ability as you see it of the VA to implement such a case management model that would coordinate VA health care services with community based social support services for the aging veteran, in particular.

To what extent do community based organizations, health and social support services for the aged currently exist in the private sector? What is their availability on a national or nationwide basis?

I know that's a long pitch, but I would appreciate brief comments on that, please.

Dr. **Brody**. The idea of case management is not a new idea. It was written about in a book called "Social Diagnosis," by Mary Richmond in 1917.

Mary Switzer, at the Rehabilitation Services Administration had case management for years. It was called vocational counselors. This is not a new concept and any well trained or master level social worker should be able to do case management.

Indeed, that's part of the role of the social worker in a VA hospital.

The problem with it is there's no supporting structure assuring continuity of care and that's really the issue.

To some extent—and Dr. Busse referred to that—many of the veterans organizations perform exactly that kind of role on a voluntary basis. What case management involves, really, is having an assessment made of the needs of the individual on a continuing basis, because needs change, and then to marshal the resources that are available both within the VA system and hopefully within the community to meet those needs; and then help the veteran use those resources.

To the best of my knowledge, I don't think it's defined quite that way within the VA system.

Perhaps the social work function within the VA should be reviewed and addressed in case management terms. It may be that VA social workers can be redeployed to perform that function within the VA.

In terms of long-term care and the availability of existing models, Donna Cohen talked about the various demonstration projects in the United States.

We're evaluating these programs at the University of Pennsylvania Rehabilitation R&T Center for HCFA. We are finding that they haven't been too successful. One of the reasons is the multiplicity of the auspices of the services.

Some services are provided directly at the Federal level; some services are provided at State level; and some at the county or municipal level. Within each level of Government, services are delivered by different agencies such as State Office on Aging or a Welfare Department.

It's very difficult at a local level to mobilize all of these services within one system.

The advantage the VA has, and I hope I stressed that, is that you already have it within a system. The best service arrangement that I know of that exists in the world outside of the VA is in South Edinborough. It has the same approach in which all of these services are under a single umbrella and not dealing with these very complex turf problems.

Chairman SIMPSON. Thank you.

Dr. Cohen, did you have any response to that general question?

Dr. COHEN. Just to be brief because I went over my 5 minutes earlier.

Chairman SIMPSON. I know.

Dr. COHEN. I second Dr. Brody's comment, but I want to expand upon it. I think the VA's an ideal place to implement this and I would like to take it beyond the social worker with all deference to Steve who's a dear old friend.

We've been given a 3-year planning grant by the Johnson Foundation to find out what the management problems are going to be. The Bronx has one of the oldest constituencies in the country and especially the old-old; 18,000 people are over age 85 in the Bronx, and the Bronx VA takes care of part of that population.

There is a need to sit down with the groups in the community and define what services the VA wants to give; whether the VA can broker them; and are current VA assessment devices adequate to define who needs what kinds of services?

I would like to go beyond Dr. Busse's comments. I think that the chronic care management or the case management approach is not just for the very frail and the very sick. If we treat the program that way it may end up breaking the system. We just can't afford it.

The chronic care management project, which I think is ideal for the GRECC's, should also look at those populations of older veterans who were at risk for institutionalization. We know some of the predictors: chronic illness, functional incapacity, economic problems, social isolation and current living circumstances.

I would like the GRECC's to be given a mandate to foster some kind of health policy committee or institute to develop the chronic care management concept. It may also be the VA can't broker the entire array of services on Dr. Brody's array.

I think the VA should take special interest in home care programs with home visits to those veterans who are at risk. They may not have the families or there may be a segment who are not as socialized as those we see in the private sector, but the home care program probably has the single biggest advantage within this concept.

Chairman SIMPSON. Thank you.

Mr. Westall, did you have any further comment?

Mr. WESTALL. No, sir.

Chairman SIMPSON. I thank all three of you very much for testifying. It's been very helpful to the committee. We appreciate it.

The final panel is a group of representatives of some of the veterans' organizations in the United States—Robert Lyngh of the American Legion; Don Schwab, director of the national legislative service of the VFW and Stephen Edmiston, the associate deputy national legislative director of the DAV.

We don't see you as much as the others of your fine organization; and Peter Currier, deputy national service and legislative director of AMVETS.

I appreciate your being here. Please proceed.

TESTIMONY OF A PANEL OF REPRESENTATIVES OF VETERANS' ORGANIZATIONS CONSISTING OF: ROBERT E. LYNGH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; STEPHEN L. EDMISTON, ASSOCIATE DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND PETER B. CURRIER, DEPUTY NATIONAL SERVICE AND LEGISLATIVE DIRECTOR, AMERICAN VETERANS OF WORLD WAR II, KOREA, AND VIETNAM [AMVETS]

Mr. **Lyngh.** Thank you, Mr. Chairman.

My name is Robert E. Lyngh and I represent the American Legion this afternoon.

We commend the Senate Committee on Veterans Affairs' for taking up this subject. The problems that will confront the VA between now and the year 2000 in dealing with the aging veteran population are massive. They will require not only conceptual and strategic planning by VA, but most definitely will require legislative support by the Congress.

Never in the history of veterans affairs in our Nation has the Government had to manage a problem of this nature and this scope. The existence of the problem itself, of course, is the result of the fact the United States has engaged in four wars in the 20th century and in doing so has created a veteran population in excess of 30 million, most of whom served during World War II between 1940 and 1946.

The American Legion does not have the capability to develop the conceptual planning necessary for this problem. We have been and we will continue to work with both Congress and VA to evaluate, appraise and lend our best judgment to the work of the professionals who are involved in this effort. We are in the role of consumer advocate and we are attuned to and responsive to the needs and desires of the veteran population.

It would be our suggestion that beyond this oversight examination the committees of Congress should undertake no definitive planning for the future of VA programs for aging veterans until the committees are in receipt of a report from the Geriatric and Gerontology Advisory Committee that was established under the legislative authority of Public Law 96-330, the VA Health Care Amendments Act of 1980.

Among the commendable features of that act, which had the support of the American Legion, was establishment of the GGAC. The members of the GGAC were appointed by the Administrator as of May 1, 1981, and have been functioning since that time.

The legislation mandated that within the membership of the GGAC should be a representative of a veterans' organization. An

American Legion representative was chosen by the Administrator for that assignment and has been working with the committee.

The Geriatric and Gerontology Advisory Committee will submit its first report to the Administrator in the near future. That first report and future reports will include specific recommendations for consideration by Congress in planning for care of aging veterans.

The committee can and will provide expert assistance to the committees of Congress and it would be our recommendation that definitive planning should wait on the results of the work and the recommendations of the GGAC.

The American Legion wants the present VA medical care program to be maintained first for the service disabled and then for those veterans who need and apply for care from the VA system.

Our position is consistent with the commitment first made to the Nation's war veterans by Congress when it passed the World War Veterans Act of 1924. Congress has taken no action to rescind that commitment.

To the contrary, Congress through the many years since 1924 has adopted a plethora of legislation to expand, modify, and improve the VA medical care program until it has become what it is today, the finest single comprehensive medical care program in the Nation.

The American Legion never expected nor intended the VA system to be large enough to accommodate 25 million war veterans. In the main, the VA system has done what it was intended to do. It has provided care for the service disabled and, beyond that, for those who have found it necessary to turn to VA for care.

The National Academy of Sciences study of 1977 found that the active clientele of the VA system comprises about 3 million of the 30 million veteran population and that the overwhelming majority of these are single, elderly, and poor.

Sixty-six percent of them were found to have no health insurance.

We believe VA should move rapidly now into the forefront of the practice of geriatric medicine. We believe the thrust of the VA effort should be toward maintaining the veteran patient for as long as possible in a community setting.

This will require bold and innovative thinking and pioneering efforts toward leading the entire Nation into the new field of geriatrics and gerontology.

In summary, let us say that VA is doing many things in the area of development of programs for the care of aging veterans. Congress has been supportive for which the American Legion is grateful.

Much more needs to be done. There will be advances in medical science and technology and caring for the aging. New modalities will be developed with the thrust toward the continuance of community living.

In the long run with the funding support that will be necessary we believe all these developments will be cost effective and that they will keep more older citizens, including veterans, in a productive capacity during their later years.

In all of these activities, most certainly, compassion and caring must be factors. This Nation must not turn its back on the young men and women who fight its wars when they become old.

The sacrifices of Iwo Jima and the Normandy Beachhead are as valuable to the Nation now as they were in 1944.

Thank you, Mr. Chairman.

Chairman SIMPSON. Thank you very much, Mr. Lyngh.

[The prepared statement of Robert E. Lyngh, director, National Veterans Affairs and Rehabilitation Commission, the American Legion, and the American Legion's response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF ROBERT E. LYNCH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to present its views to the Committee on the subject of Veterans Administration Programs for aging veterans.

We commend the Senate Committee on Veterans Affairs for taking up this subject. The problems that will confront the Veterans Administration between now and the year 2000, in dealing with the aging veteran population are massive. They will require, not only conceptual and strategic planning by VA, but most definitely will require legislative support by the Congress. Never in the history of veterans affairs in our nation has the Government had to manage a problem of this nature and this scope. The existence of the problem itself, of course, is the result of the fact that the United States has engaged in four wars in the Twentieth Century, and in doing so has created a veteran population in excess of 30 million, most of whom served during World War II, between 1940 and 1946.

The American Legion does not have the capability to develop the conceptual planning necessary for this problem. We have been, and we will continue working with both Congress and VA to evaluate, appraise and lend our best judgment to the work of the professionals who are involved in this effort. We are in the role of consumer advocate, and we are attuned to and responsive to the needs and desires of the veteran population.

To define the scope of the problem, let us first set forth a few of the pertinent statistics - trying at the same time to avoid burying ourselves in a wealth of numbers. The statistics we offer are from the VA Office of Reports and Statistics.

There are today 12 million veterans between the ages of 50 and 65. The average age of the WW II veteran today is 60.5 years. By September 30, 1986 there will be 5.5 million veterans over the age of 65. By September 30, 1991 this figure will rise to 7.8 million. The peak year for WW II veterans over age 65 will be 1992, when there will be 7.9 million of them. By year 2000 there will be 9.2 million veterans of all wars who are past the age of 65. In 1981 the mortality rate for WW II veterans was 250,000 per year.

And, to further place our remarks in context with the problem, let us offer the following figures from the VA Department of Medicine and Surgery.

In the VA system, there are on line today 9,287 nursing home care beds. The monthly turnover rate in these beds is 5%, and the Bed Occupancy Rate is 95%. By the end of Fiscal Year 1987, VA plans to have on line 13,100 nursing home care beds. Planned to come on line during FY 1982 are 480 beds; FY 1983, 348 beds; FY 1984, 480 beds; and FY 1985, 320 beds. It must be added that all NHC beds planned for beyond FY 1983, are subject to the revalidation process initiated by the Administrator.

In the area of Domiciliary facilities, there were on line as of May 31, 1982, 8,243 beds, with an Average Daily Patient Census on that date of 7,164. Future planning for the Domiciliary Program waits on reports within the Medical District Initiated Planning Program (MEDIPP) that is now underway in DM&S. We shall have a few words to say about the Domiciliary Program before the conclusion of our remarks.

Our statistics on the Nursing Home Care Beds do not include beds now available or planned for the Contract Nursing Home category. That program appears to fluctuate depending on local need as against availability of VA operated nursing home care beds.

As of today, combining nursing home care and domiciliary, there are 17,530 long-term care beds available within the VA system. There are also on line 10,557 intermediate care beds. This number has not varied appreciably during the past five years. Intermediate care beds do serve an important purpose in freeing up beds for patients experiencing acute episodes of illness.

We stated at the beginning of this presentation that we commend the Committee for addressing the problem of VA programs for aging veterans, and we do. However, it would be our suggestion that beyond this oversight examination, the Committees of Congress should undertake no definitive planning for the future of VA programs for aging veterans until the Committees are in receipt of a report from the Geriatric and Gerontology Advisory Committee that was established under the legislative authority of Public Law 96-330, the Veterans'Administration Health-Care Amendments Act of 1980. Among the commendable features of that Act, which had the support of The American Legion, was establishment of the GGAC. The members of the GGAC were appointed by the Administrator as of May 1, 1981, and have been functioning since that time. The legislation mandated that within the membership of the GGAC should be a representative of a veterans organization. An American Legion representative was chosen by the Administrator for that assignment, and has been working with the Committee.

The Geriatric and Gerontology Advisory Committee will submit its first report to the Administrator in the near future. That first report, and future reports will include specific recommendations for consideration by Congress, in planning for care for aging veterans. The Committee membership is composed of persons with outstanding credentials in the field of Geriatrics and Gerontology. The Committee can and will provide expert assistance to the Committees of Congress, and it would be our recommendation that definitive planning should wait on the results of the work and the recommendations of the GGAC.

It should also be mentioned that PL 96-330 mandated the establishment, within the Department of Medicine and Surgery, of the position of Assistant Chief Medical Director, trained and experienced in the field of geriatrics. This has been done, and that office is now functioning in DM&S.

Let us speak now to the current perception of The American Legion as to the problems of VA care for aging veterans.

It is clear that the impact of the aging veteran population is already beginning to be felt by VA, as witness, among other things, the 95% ADPC of the Nursing Home Care Units, and the fact that practically all of them have waiting lists.

Acute care beds within VA are already seeing more of the catastrophic illnesses that are associated with advancing age, such as heart disease, stroke and malignancies. We believe VA is dealing with these as well as it can, with its present resources, and recognizing that the maximum level of anticipated impact yet lies ahead.

It cannot be said the VA Department of Medicine and Surgery has not done planning and instituted initiatives with reference to aging veterans, as witness the planned increase in nursing home care beds and the eight current Geriatric Research, Education and Clinical Units. It is to be noted that a total of 15 of these GRECCs are authorized by Public Law 96-330, although funding for the additional seven has not been provided.

Our observation in visiting the current GRECCs with the GGAC is that some of them are marginally funded, and thus, the extent of their efforts is limited.

Without wishing to supersede the conclusions of the GGAC, which are yet to be formulated, we would say the current impact of the existing GRECCs is limited by their funding, and perhaps by the absence of more detailed guidance and support from Central Office. That the GRECCs are doing some good is definitely true. They are carrying out innovative and effective programs in the three areas of research, education and clinical care - perhaps the latter most modestly. It would seem to this observer that perhaps it is now time for Central Office to provide guidance and support that would lead to the implementation of GRECC proven approaches to geriatric medicine more comprehensively throughout the VA system. In other words, it would be good if what the GRECCs are doing - that has been so far proven effective, could be extended to the practice of medicine on the general care wards of the medical centers. The GRECCs have now been functioning for some eight years. It is time, it would seem, that more patients could share the beneficial effects of what the GRECCs have learned.

It is our belief also that more funding and encouragement, from Central Office and from Congress could and should be directed to the research efforts of the GRECCs. Basic research in the field of geriatric medicine is much needed - by the general field of medicine; and VA, as it has in some other fields, such as hypertension, could be a leader in this area, in part because of its increasing aged clientele.

We will not extend our remarks in this direction, because we, too would like to wait on the findings and recommendations of the GGAC.

The American Legion is very supportive of such programs as Hospital Based Home Care and the Foster Home Program. Our observation is that Hospital Based Home Care is a popular program with the professionals who are engaged in it. It seems to be accepted in medicine that it is better to treat and maintain the patient in a home atmosphere than in the sterile surroundings of the hospital. The problem with Hospital Based Home Care is to make the program cost-effective. In most places the teams operate only within a fifty mile radius of the medical center. But they do much good. The teams are enthusiastic about their work, and their patients are happy to be at home with their families. This is also true for the Foster Home Program, where the patient lives - at his own expense in a foster home, and is medically managed by the medical center.

These programs are community oriented, and are in line with current thinking in medicine that it is better to maintain patients de-institutionalized as much as, and for as long as possible. All of this ties in with the accepted postulate that quality of life is an essential ingredient of life itself.

If the forward movement of the practice of medicine in the VA Department of Medicine and Surgery is toward providing care for the veteran as much as possible in a de-institutionalized setting, then this is going to create problems for both VA and Congress. The question is going to be - can community based programs be made cost-effective - and can the nation afford them. We of the Legion support the theory of maintaining the veteran patient in the community as much as and for as long as possible. We recognize too, that there are limits to what the Government can afford, even in the application of advanced principles in the practice of modern medicine.

The only practical approach we see to this matter at present is for the Congressional Committees to work with VA, and with the Congressionally mandated Geriatric and Gerontology Advisory Committee, to develop programs that answer the needs of aging veterans, within the parameters of accepted medical practice in today's world; put cost figures to these programs, and then determine what the Government can afford, and perhaps how the projected programs can be adjusted to make them affordable.

The fundamental proposition put forward by The American Legion in a discussion of this nature is that the Government of the United States must not and cannot turn its back on the aging veteran population.

That is not what the young men and women of 1940 were told when they were sent forth to conquer Hitler and Tojo. What they were told was that if they would go out and win their war - their Government would never forget them. Franklin Roosevelt and the leaders of Congress in 1940 did not say "We will never forget you - until you get old - and then we will forget you, because then you will be too expensive."

That thought, Mr. Chairman, leads us to address the fact that some leaders in this Government, both in the Executive and the Legislative Branches have been making statements that the Government cannot, in fact provide care for all the veterans who are now reaching and passing the age of 65. We will tell you frankly that the Administrator has said to American Legion groups that there are too many veterans 65 years of age, and the Government cannot afford care for them all.

The American Legion reaction to that statement is hostile. We have tried to point out to the Administrator that nobody has ever said or expected the Government to provide care to all veterans who are 65. What the law says is that veterans who are 65 are entitled to care when needed and applied for, without regard to their ability to pay for such care - to the extent that VA resources are available. Please note carefully the final clause of that statement. To the extent that resources are available.

In the first place, more than half the veteran population has never applied for VA medical care - and never will. Most veterans take care of themselves - just like all other citizens. Those who can be expected to apply for VA care are those in the lower economic categories who are suffering with catastrophic illnesses. The American

Legion works in all 172 VA hospitals - every day. If there are any millionaires in those hospitals - we have yet to see them. Most millionaires, when they become ill - rent the finest suites in the best hospitals that money can buy - why would they want to go to a VA hospital, where they would have to associate with poor people?

Based on his public statements, it is our opinion the Administrator either does not understand the laws and regulations that govern the VA medical care program, or that he does not accept their philosophical rationale.

The American Legion wants the present VA medical care program to be maintained, first for the service disabled, and then for those veterans who need and apply for care from the VA system. Our position is consonant with the commitment first made to the nation's war veterans by Congress, when it passed the World War Veterans Act of 1924. Congress has taken no action to rescind that commitment. To the contrary, Congress, through the many years since 1924 has adopted a plethora of legislation to expand, modify and improve the VA medical care program, until it has become what it is today, the finest single comprehensive medical care program in the nation.

The American Legion never expected, nor intended the VA system to be large enough to accommodate 25 million war veterans. In the main, the VA system has done what it was intended to do. It has provided care for the service disabled, and beyond that, for those who have found it necessary to turn to VA for care. The National Academy of Science study of 1977 found that the active clientele of the VA system comprises about 3 million of the 30 million veteran population, and that the overwhelming majority of these are single, elderly and poor. Sixty-six percent of them were found to have no health insurance.

Having stated our fundamental beliefs in this regard, let us return then to accommodating these beliefs to the particular problems of the aging veteran - which will comprise the largest segment of the veteran population for the foreseeable future.

We believe VA should move rapidly now into the forefront of the practice of geriatric medicine. We believe the thrust of the VA effort should be toward maintaining the veteran patient for as long as possible in a community setting. This will require bold and innovative thinking, and pioneering efforts toward leading the entire nation into the new field of geriatrics and gerontology. For it is not only the veteran population that is getting older. With advancing longevity, the entire American people are getting older. Modalities developed for care and treatment of veterans will, in many instances be applicable generally, and VA can be a leader, just as it has been in other areas of medical science.

We realize the cap on all this will be what the Government can afford. We do not expect unrealistic commitments by the Congress. Most veterans will continue to care for themselves, as they have always done. They will use their entitlement to Medicare - and for those who need it, Medicaid. But there will be those who will turn to the VA system. We of the Legion certainly do not want the VA system, at this juncture, to be reduced in size. That is why we continue to seek to persuade VA not to reduce its bed capacity any further than it has already done. We are sure the demand for bed service will increase, as more older veterans are stricken with catastrophic illness.

Among the innovative approaches, we would like to see VA move forward in the hospice - or palliative treatment area. This is an acceptable aspect of medical practice and will become increasingly important.

The American Legion supports the Domiciliary Program. We do not want to see it materially reduced from its present level. The point is that there will continue to be some veterans who, by reason of physical condition, income limitation and psychological adjustment, will need the security of an institutional atmosphere. VA now has introduced therapeutic approaches to try to prepare these veterans for a successful return to community living. The American Legion supports that therapeutic effort, and will assist it in every way possible. But we do not want VA to turn its back on those who need institutional support.

It is true that many older veterans suffer from alcohol abuse. This is certainly not peculiar to the veteran population, since alcoholism is endemic among the American people. Alcoholism is an identified pathological condition that is susceptible to treatment. Veterans with alcohol problems are ill, just like anybody else. VA has done pioneer work in treating this problem, and Congress has been supportive - to its credit. We support the treatment programs in VA medical centers, and we support the Halfway House program, authorized by Congress, and which assists the recovering alcoholic to return to the community in a physically and economically viable condition.

In summary, let us say that VA is doing many things in the area of development of programs for the care of aging veterans. Congress has been supportive, for which The American Legion is grateful. Much more needs to be done. There will be advances in medical science and technology in caring for the aging. New modalities will be developed, with the thrust toward the continuance of community living. In the long run, with the funding support that will be necessary, we believe all these developments will be cost-effective, in that they will keep more older citizens, including veterans, in a productive capacity during their later years. In all of these activities, most certainly, compassion and caring must be factors. This nation must not turn its back on the young men and women who fight its wars, when they become old. The sacrifices of Iwo Jima and the Normandy Beachhead are as valuable to the nation now as they were in 1944.

The American Legion has said, and says again that the nation that forgets its war veterans is in danger of losing its soul. We do not believe that is going to happen in our country.

Thank you.

RESPONSE OF THE AMERICAN LEGION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. In your personal opinion, what direction should the VA health-care system take during the next few decades, in order to balance the health-care needs of all veterans and respond effectively to the changing needs of millions of new elderly eligible veterans?

Answer 1. We believe VA should press forward in all areas of the developing aspects of geriatric medicine, including such fields as gero-psychiatry, palliative care, rehabilitation medicine, and such other specialized fields as will enhance the quality of life for an aging population.

Additionally, we believe that basic research into the medical problems of the aging are absolutely essential to the overall VA effort to respond to the aging veteran population.

There should be continued development of treatment for aging aspects of ambulatory care, hospital based home care, foster home care, nursing home care, and any other initiatives that will be salutary to the veteran and cost-effective to the VA.

Question 2. Please comment on the need and the ability of the VA to utilize the so-called "case management" model, which would coordinate VA health-care and other benefits with community-based organization services for the aged.

Answer 2. We are not completely briefed on the particulars of the "case-management" model, but we will be supportive of initiatives that will strengthen coordination of VA programs with community-based organizations and programs for older persons. We believe this is a natural and desirable projection of the VA overall effort for aging veterans.

Question 3. What barriers do you believe exist in the VA health-care system which may prevent the "de-institutionalization" of its aging population?

Answer 3. We believe a review of current legislative authority should be undertaken, looking to development of any additional legislation that may be necessary to clarify and extend VA authority to pursue all methods of enhancing quality of life programs for aging veterans through cost-effective means.

Question 4. Would you comment on the effectiveness of the present role of the VA GRECCs in the agency's overall program of providing health care to eligible veterans? Please address each of the three program areas of geriatric care, i.e., research, education, and clinical activities.

Answer 4. An American Legion representative has been serving on the VA Geriatrics and Gerontology Advisory Committee, authorized by PL 96-330. This Committee has completed site visits to each of the currently functioning GRECCs. We can summarize our comment as to all three aspects of the GRECCs - research, education and clinical: 1) collectively they are all doing good and useful work, though not all at the same levels of effectiveness and productivity; 2) mostly they are underfunded, which limits their effectiveness and productivity; 3) there needs to be more emphasis now, after eight years' experience, on the clinical function - actual treatment of patients; 4) after eight years' experience, more of the GRECCs' collective acquired knowledge and experience should be transferred to the overall clinical activities of the VA system; 5) the additional 7 GRECCs authorized by PL 96-330 should be funded - this is because the Legion is persuaded this is a cost-effective method through which VA can address the multiple problems confronting the agency in dealing with a large aging veteran population.

Question 5. Many people have stated recently that VA resources should be transferred to correspond with geographic population movements to the sunbelt areas. Please comment on Dr. Custis' statement that the decreased veteran population in the northeast areas will not result in a corresponding decreased demand there for VA health-care services.

Answer 5. We agree with Dr. Custis that the migration to the sunbelt states will not significantly diminish the demand for services on the medical centers and clinics in remaining parts of the nation. This is because, despite the migration, there remain large segments of the veteran population that will not migrate, but will choose to live out its life cycle in its usual and home environment. The American Legion will, however, support a program to survey and where necessary redefine the mission of all VA medical centers and clinics - to assure that at the present time they are configured and designed to meet the needs of their natural clientele. If such a survey clearly demonstrates the need to change the assigned mission of some facilities, the Legion will support such change.

Chairman SIMPSON. Don Schwab, please.

Mr. SCHWAB. Thank you, Mr. Chairman.

My name is Donald H. Schwab and it is my privilege to serve the 1.9 million men and women of the Veterans of Foreign Wars as their legislative director.

The gentleman on my left is Lynn Ilgin, a field representative in our National Veterans' Service whose primary function is to survey VA facilities.

We're delighted, of course, that you're holding this hearing with respect to aging veterans.

Not to be redundant and go over ground we've already covered, one of our recommendations would be, Mr. Chairman, that some of the 17,000 hospital beds that consistently remain vacant within the Veterans' Administration be converted to nursing home care beds.

The VA, whether they had 110,000 beds or the 80,000 they have now, has constantly run at an average of 20 percent empty beds.

I know that the committee is looking for alternate and innovative ways to provide care for aging veterans and the growing veteran population in that age group, but I would suggest to you, Mr. Chairman, there are already on the books laws to provide innovative care for veterans; they just have not been funded.

The VA hospital based home care program authorized by Public Law 98-382 is a fine and cost effective program. There are 26 medical centers participating in this home based health care program.

But, due to the absence of additional funding no activations have been made since 1974. You will recall that Public Law 96-330 authorized expanding the geriatric units from 8 to 15; that funding was to have been $10 million in 1981; $25 million in each of the following 3 years; and not 1 dime has been appropriated for expansion of that program.

All the VA has been able to do in this current budget is to add three employees to bring the eight GRECC's up to strengh.

Public Law 96-22 established a 5-year pilot program of preventative health care services. This program was to receive a maximum funding of $10 million in 1980; $12 million in 1981; $13 million in 1982; $14 million in 1983; and $15 million in 1984. No funding has been specifically appropriate for that program.

Those at the VA have informed us they have only received a "dribble of money" in that area.

Public Law 96-466 provided for a 4-year pilot program of independent living and assistance for severely disabled veterans. That's been a law for 20 months and, according to the VA, only 17 veterans of the 500 authorized through this pilot program are participating in it. As a matter of fact, on the 17th of this month the VA sent out a news release captioned "VA Seeks Veterans for a New Independent Living Service Program."

So in conclusion, Mr. Chairman, it's the position of the VFW the VA just cannot suffer repeated reductions in their proportion of the Federal budget and continue to furnish services to service-connected veterans and non-service-connected veterans in need who seek such care.

We believe that as long as there is money to furnish health care to welfare beneficiaries who have done nothing for this Nation, aliens, boat people and refugees, not one veteran should be denied care for the lack of funds.

That concludes my testimony. I'll be happy to respond to any questions you may have, sir.

Chairman SIMPSON. No, I don't, right now. I'll think of one, though.

Mr. SCHWAB. All right, sir.

[The prepared statement of Donald H. Schwab, director, national legislative service, Veterans of Foreign Wars of the United States, and the VFW's response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follow:]

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

PREPARED STATEMENT OF

DONALD H. SCHWAB, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO OVERSIGHT OF EXISTING VETERANS ADMINISTRATION
HEALTH CARE PROGRAMS AND POLICIES WHICH AFFECT THE NEEDS OF AGING VETERANS

WASHINGTON, D. C. JUNE 30, 1982

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the privilege of appearing before this distinguished Committee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab, and it is my privilege to serve the more than 1.9 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

Mr. Chairman, the Veterans Administration extended care program is tailored to the needs of older veterans and embraces long-term care in VA and community nursing homes, domiciliary care, hospital-based home care, residential care, all care in state home facilities, and the Geriatric Research, Education and Clinical Care Program. The necessity for these programs is quite evident since the

Veterans Administration is going to be faced with an unprecedented older veteran population. There are presently 3.2 million veterans 65 years of age and older, and according to "A Report On The Aging Veteran," this age group will peak at eight million in 1995. However, and as we have previously stated, it is not anticipated a substantial number of World War II veterans will impact on the VA system. There will, no doubt, be an increased demand for geriatric care and it would behoove the VA to accelerate preparations in this area of care.

Mr. Chairman, Public Law 97-72 requires the Administrator of Veterans Affairs to maintain not less than 90,000 hospital and nursing home care beds over which he has direct control and such other beds as deemed necessary to fulfill the VA's contingency responsibility to the Department of Defense. Presently there are 80,163 operating hospital beds and 8,988 nursing home care beds. The average daily census for hospital beds has consistently remained at approximately 80 percent of capacity and for nursing home care beds, the average is presently 93.4 percent. More than 70 percent of the veterans receiving nursing home care in VA facilities are in receipt of either compensation or pension and it is most difficult to gain admittance for a veteran to nursing home care. In view of the fact that approximately 17,000 hospital beds remain empty, the VFW suggests, as we have before, that a portion of these empty beds be converted to nursing home care beds which are going to be even more in demand in the next several years.

In addition to the foregoing, nearly 9,000 veterans are receiving nursing home care by VA contract with community nursing homes and more than 6,000 veterans are cared for by state home nursing care units. Therefore, approximately 24,000 veterans are receiving nursing home care funded in whole or in part by the Veterans Administration.

Mr. Chairman, the VA presently operates 16 domiciliaries for predominantly older and ambulatory veterans in need of professional care, but neither hospitalization nor skilled nursing care. Approximately 70 percent of the average 8,000 residents in domiciliaries are in receipt of compensation or pension and their average stay is approximately four years. Per diem costs average $28.48. The VA program in preparing veterans to return to community living is highly commendable and significantly reduces the occurrence of domiciliary residents becoming institutionalized. The VFW believes this program fills a very definite need and not only should be continued, but expanded due to the increasing number of aging veterans who may need such care. Thirty-seven state home domiciliaries provide similar care to approximately 5,000 veterans.

As is a matter of record, Mr. Chairman, the VA hospital-based home care program was established by Public Law 93-82, approved August 12, 1973 and is encoded as 38 USC 612(a). In addition to providing home health services to chronically ill veterans, when the Administrator deems it necessary or appropriate, he may also authorize structural alterations of the veteran's home to include lavatory and sanitary facilities not to exceed $2,500. This is a good and cost effective program which, unfortunately, has not been expanded due to the absence of adequate funding. Twenty-six VA Medical Centers presently participate in home-based health care and the last activation of such units was in January 1974. A listing of the participating facilities is appended to my testimony.

Mr. Chairman, the Residential Care Program provides room board, personal care and general health care supervision to veterans not requiring more skilled care but, who because of health conditions are unable to resume independent living and have no suitable family resources. This care is provided in private homes selected by the VA and paid for in full by the veteran. The VA is unable to establish uniform standards for such homes due to the variance in state and community laws. These homes fulfill a very definite need at minimal cost to the VA.

However, the success of individual homes is contingent upon the adequate staffing of VA social workers. Residents receive outpatient care at local VA facilities. Unfortunately, there are no provisions in existing law allowing the outplacement of indigent veterans to this type care.

Mr. Chairman, the VA's Geriatric Research, Education and Clinical Centers Program (GRECC's) is a matter of great concern to the VFW and one we believe is, unfortunately, being given short-shrift. One of the provisions of Public Law 96-330 authorized expansion of GRECC's from the present eight to as many as 15. Funding was to have been $10 million in the fiscal year 1981 and $25 million each of the following three fiscal years. Notwithstanding the obvious and growing need for expansion of the GRECC's, no money has yet been appropriated for this purpose. Pointing out the slow progress in this program, you will recall that the proposed new facility in Camden, New Jersey was first reduced in size and then canceled. This was to have been a model Geriatric Center. Compounding the problem, it was brought out at the recent oversight hearing with respect to outpatient facilities that few physicians are skilled in geriatrics. The proposed funding for the eight existing GRECC's merely adds three employees to bring the staffing level up to authorized standards. In my testimony before the Subcommittee on HUD-Independent Agencies of the Senate Appropriations Committee last month, I pointed out the absence of funding to expand the GRECC Program and the crucial need which was recognized by Congress when, on the same day, both the House of Representatives and the Senate overrode the President's veto of the enacting legislation.

Mr. Chairman, presently 32 states operate some 45 State Veterans' Homes which are the beneficiaries of two VA grant programs. Under the first, the VA will financially assist the funding for construction of new nursing home and domiciliary facilities or the renovation of existing ones with a grant of 65 percent of the cost. Under the provisions of 38 USC 641, the other grant program pays each state per diem in the amount of $6.35 for domiciliary care, $12.10 for nursing home care and $13.25 for hospital care for each veteran. State Homes provide a highly cost-savings supplement to VA extended care programs. The VFW has historically supported both grant programs before this and other committees in both houses of Congress.

Public Law 96-22 established a five-year pilot program of preventive health care services for veterans with 50 percent or more service-connected disability ratings and for veterans receiving treatment involving a service-connected disability, using interdisciplinary health care teams. This program was to receive the maximum funding of $10 million in the fiscal year 1980, $12 million in 1981, $13 million in 1982, $14 million in 1983 and $15 million in 1984. No funding has been specifically appropriated for this program and VA information sources indicate only a "dribble of money" has been provided for this program.

Mr. Chairman, one of the provisions of Public Law 96-466 provides a four-year pilot program of independent living and assistance for severely disabled veterans for whom vocational rehabilitation is not reasonably feasible. The pilot program is limited to 500 veterans and requires the Administrator to submit a report to Congress by September 30, 1984 with respect to its effectiveness. It is my understanding that although the law has been in effect for 20 months, only 17 veterans are participating in the program. As a matter of fact, on the 17th of this month the VA issued a news release captioned, "VA Seeks Veterans for New Independent Living Services Program."

Mr. Chairman, you know that the VFW is highly disturbed by the freeze placed on 56 construction projects by the Administrator of Veterans Affairs for the purpose of revalidation. Although we are reasonably certain most of the projects will be revalidated since they were fully justified by the VA and approved at the appropriate level established by law, we fear some projects will be deferred and repeated deferment ultimately leads to cancelation due to escalating costs. Among the construction projects being revalidated are eight nursing care units and two domiciliaries which are obviously greatly needed.

Mr. Chairman, it serves no useful purpose for the Congress to authorize programs related to the health care of veterans and then fail to adequately fund those programs and, in addition, places an unfair budden on the Department of Medicine and Surgery in attempting to meet the mandated requirements and submit reports to Congress. As I pointed out during the recent hearing on VA outpatient care, veterans and their health care programs are not the ones going to break the bank. As a matter of fact, the VA budget accounts for less and less of the Federal budget and this situation must be reversed and soon or, breaking an historical precedent, Congress will be responsible for relegating large numbers of veterans to the status of welfare beneficiares and this, you know, the VFW will fight with every resource at its disposal.

Mr. Chairman, also appended to my testimony are Resolutions passed by the voting delegates to our last National Convention which are pertinent to the subject of this hearing as follows:

Resolution No. 621 -- "VA Plan For Aging Veterans"
Resolution No. 717 -- "Matching Fund Construction Grants To States"
Resolution No. 721 -- "Non-Expiring Nursing Home Care For WWI Veterans"
Resolution No. 781 -- "Support Legislation To Improve VA Delivery Of Geriatric And Extended Health Care Services"

This concludes my testimony, Mr. Chairman, and I will be happy to respond to any question you may have. Thank you.

VETERANS ADMINISTRATION

[illegible]

HOSPITAL BASED HOME CARE

ACTIVATION	STATION
July 1972 (7)	Albany
	Hines
	Long Beach
	Miami
	Minneapolis
	New Orleans
	Pittsburgh (UD)
July 1973 (9)	Bay Pines
	Birmingham
	Boston
	Houston
	Little Rock
	Philadelphia
	San Francisco
	Washington
	White River Junction
January 1974 (10)	Albuquerque
	Allen Park
	Atlanta
	Buffalo
	Cleveland
	Dallas
	East Orange
	Indianapolis
	Iowa City
	Portland
	Richmond
	San Diego
	St. Louis
	Seattle

NOTE: As early as 1969, six stations volunteered to enter this program with funding from local resources. It was seen then as a post hospital care type of health delivery and covered under the broad outpatient treatment authority. Initial funding for program was July 1972. Also, Brooklyn, an original participant could find no physicians willing to participate; as a consequence the program was shifted to Hines.

Resolution No. 621

VA PLAN FOR AGING VETERANS

WHEREAS, the Veterans Administration has already sustained disproportionate budgetary and personnel cuts; and

WHEREAS, operating hospital beds have been slashed from 121,000 in the 1940's when there were 15 million veterans to a planned patient census of 64,000 in F.Y. '82 with a veteran population of 30 million; and

WHEREAS, from 1990 on, more than half of all American males over 65 will be veterans with an undetermined number requiring some classification of extended care; and

WHEREAS, Congress has recognized the nation's responsibility to improve and expand the capability of VA health care facilities to respond to the needs of an increasing number of older veterans by passage of P.L. 96-330, which is stymied by OMB's refusal to provide funds for its implementation; and

WHEREAS, there has been a demonstrated reluctance by medical schools affiliated with the VA to address this special need and incorporate it into their teaching program as a medical specialty; and

WHEREAS, the Veterans Administration must of necessity revise its current configuration of health care and other services to meet the demands imposed by this growing population of aging veterans; now, therefore

BE IT RESOLVED, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, that the Veterans Administration provide the Congress with a comprehensive plan to meet the needs of the aging veteran.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

Resolution No. 621

Resolution No. 717

MATCHING FUND CONSTRUCTION GRANTS TO STATES

WHEREAS, the Congress of the United States has continuously provided medical, domiciliary, and nursing care to the nation's veterans; and

WHEREAS, the Veterans Administration has worked with many states to develop hospital, domiciliary, and nursing care facilities to provide care for the veterans; and

WHEREAS, many of the states with financial support from the Veterans Administration have provided hospital, domiciliary, and nursing care to veterans in cooperation with the Veterans Administrations; and

WHEREAS, there is a continued need to provide nursing care to the nation's veterans above and beyond the level that can be provided by individual states or the federal government, however, in a joint venture these services can be expanded to the older veterans; now, therefore

BE IT RESOLVED, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, that we go on record requesting the Congress to provide increased funding to the Veterans Administration for the purpose of matching state funds to expand the state veterans hospital, domiciliary, and nursing care services; and

BE IT FURTHER RESOLVED, that the Veterans Administration shall negotiate from time to time the Veterans Administration reimbursement costs to states for care of such eligible veterans.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

Resolution No. 717

Resolution No. 721

NON-EXPIRING NURSING HOME CARE FOR W.W.I. VETERANS

WHEREAS, PL 96-151 authorized the veterans of World War I and Mexican Border Campaign the same privileges as the veterans of World War II, Korea and the Vietnam Era for outpatient treatment and other medical benefits; and

WHEREAS, these benefits authorized outpatient treatment for the World War I and Mexican Border Campaign the same as the service connected veterans but not nursing home care on a non-expiring contract; now, therefore

BE IT RESOLVED, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, that Title 38 United States Code be amended to permit indefinite outplacement of World War I veterans to community nursing homes operated under VA auspices.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

Resolution No. 721

Resolution No. 781

SUPPORT LEGISLATION TO IMPROVE VA DELIVERY OF GERIATRIC AND EXTENDED HEALTH CARE SERVICES

WHEREAS, the demand for geriatric and extended health care and medical services being placed upon the VA is rapidly increasing; and

WHEREAS, by 1980, there will be nearly 3 million veterans 65 years of age or older; by 1985, there will be almost 5 million such veterans; and by 1990, this figure is projected to jump to over 7 million veterans 65 years of age or older; and

WHEREAS, the VA has instituted a Geriatric Research, Education and Clinical Centers Program (GRECC), to "... give visibility and respectibility to geriatrics and, by creating centers of interest and activity, exploit available old resources and develop enthusiastic new practitioners, teachers, and researchers in the field;" and

WHEREAS, the VA hospital system should be the leader in geriatric research, training, and care, due to the extensive network of VA facilities and the scope of medical care now provided; now, therefore

BE IT RESOLVED, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, that we go on record and urge the expansion of the VA's role in the delivery of geriatric health care service to meet head-on the documented need of such health care services.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981

Resolution No. 781

RESPONSE OF THE VETERANS OF FOREIGN WARS OF THE UNITED STATES TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. In your personal opinion, what direction should the VA health-care system take during the next few decades, in order to balance the health-care needs of all veterans and respond effectively to the changing needs of millions of new elderly eligible veterans?

Answer 1. The Senate Veterans' Affairs Committee during past Congresses demonstrated considerable foresight in shepherding through legislation addressing many of the health-care needs of veterans, including older veterans, in the foreseeable future. However, the failure to fund at all, or the underfunding of, the Physicians and Nurses Scholarship Program and the Expanded Geriatric Research, Education and Clinical Centers Program authorized by Public Law 96-330, the VA Hospital-Based Home Care Program established by Public Law 96-82, the Preventive Health Care Services authorized by Public Law 96-22, the Independent Living and Assistance Program authorized by Public Law 96-466, and the Construction and State Grants Programs have effectively negated many of the meritorious intentions of Congress. As the Chief Medical Director of the Veterans Administration, Dr. Donald L. Custis, stated, and as the VFW has maintained, "...I do not believe that the VA Department of Medicine and Surgery is going to be overwhelmed on a given day by demands to provide total care of all 9 million veterans over 65 in the year 2000, or all 7.7 million in 1990.

Question 2. Please comment on the need and the ability of the VA to utilize the so-called "case management" model, which would coordinate VA health-care and other benefits with community-based organization services for the aged.

Answer 2. My only knowledge of a "case management system" is contained in the gratuitous recommendations to the Veterans Administration for long-term health-care planning by Dr. Donna Cohen of the Albert Einstein College of Medicine in the Bronx, New York. However, the VFW has historically supported the sharing of information and limited resources with community facilities. The VFW would, of course, oppose any overture to "mainstream" or further contract out veterans health care to community facilities.

Question 3. What barriers do you believe exist in the VA health-care system which may prevent the "de-institutionalization" of its aging population?

Answer 3. In my opinion, the greatest barrier to the de-institutionalization of veterans within the VA health-care system is not the VA, but, rather, the absence of an available caring family, particularily in the case of psychiatric patients. The VA program for preparing domiciled veterans to return to community living is highly commendable.

Question 4. Would you comment on the effectiveness of the present role of the VA GRECCs in the agency's overall program of providing health care to eligible veterans? Please address each of the three program areas of geriatric care, i.e., research, education, and clinical activities.

Answer 4. The Expanded GRECC Program authorized by Public Law 96-330 was to have been funded in the amount of $10 million in FY '81 and $25 million in each of the following three years. To date no funds have been appropriated for expansion of the GRECCs. This is unfortunate, indeed, due to the obvious need for expanded knowledge and care in gerontology and geriatrics. With respect to research, Dr. Ewald W. Busse, Chairman of the Geriatrics and Gerontology Advisory Committee of the VA, pointed out during the hearing that of the VA medical and prosthetic research budget only about $3.3 million or 2.6 percent is devoted to aging research which is wholly inadequate to satisfy the provisions of Title III of Public Law 96-330. Dr. Busse further indicated that the existing eight GRECCs have attracted excellent clinicians and scientists. The Chief Medical Director, Dr. Donald L. Custis, opined that the GRECCs are more effective in research and education than in the delivery of patient care and that more resources are needed. I believe it was brought out during the prior hearing with respect to outpatient care that few, if any, clinics are staffed with health-care personnel specifically schooled in geriatrics. Again, if the program is to fulfill the need as envisioned by Congress it must be fully funded.

Question 5. Many people have stated recently that VA resources should be transferred to correspond with geographic population movements to the sunbelt areas. Please comment on Dr. Custis' statement that the decreased veteran population in the northeast areas will not result in a corresponding decreased demand there for VA health-care services.

Answer 5. I must agree with Dr. Custis that increased demand for health care for veterans in the Sunbelt states will not necessarily decrease the demand for care in Northeastern states. According to Volume 2 of the VA Budget: "VA users have lower incomes, are more often not married, are generally older, are more often disabled, and are more often members of minority groups" and such veterans simply do not have the stamina and financial means to migrate at will. Although the ratio of service-connected and nonservice-connected veterans seeking care may alter in Northeastern states, the undiminished if not increased need will still be present.

Chairman SIMPSON. Mr. Edmiston, please. We'd like to hear your comments.

Mr. EDMISTON. Thank you. It's a pleasure to be here this morning, Mr. Chairman, on behalf of the 720,000 members of the Disabled American Veterans.

The text of my testimony sets forth many facts and statistics regarding VA health care and the aging veteran. Upon reviewing the extent of the health care programs and benefits which have been provided veterans, there is no doubt that the American people support health care programs for those who served in the military service of this country.

However, this committee, indeed the entire Congress is facing an inevitable showdown within the very near future. As you know, the country will have an extremely large aged veteran population which, by reason of age alone, will require more episodes of acute hospital care and longer periods of chronic extended care.

Given the present constraints within which funding and facilities have been made available to provide health care benefits to veterans by the VA, the size and needs of a rapidly aging veteran population and the eligibility for VA health care, it is quite evident that the Congress must decide and decide soon the role the VA health care system will play in dealing with this fast approaching situation.

Quite frankly, dealing with the health care needs of aging veterans is synonymous with dealing with the health care of all older Americans. In the past 40 years, the VA has been a leader in the medical community as evidenced by the many contributions it has made to medical research, medical administration and patient care which has directly and indirectly benefited all Americans.

Should not the VA again be in the forefront of improving health care for all aging Americans?

Mr. Chairman, we believe this question must be answered in the affirmative so that veterans, the VA, the medical community and the entire country can move forward to respond to the health-care needs of older veterans and, indeed, our entire aged citizenry.

Quite frankly, we cannot expect those in the private medical sector to meet the needs of our aging population unless someone like the VA takes the leadership role.

That concludes my remarks, Mr. Chairman.

Again, it's a pleasure to be here.

Chairman SIMPSON. Thank you very much.

[The prepared statement of Stephen L. Edmiston, associate deputy national legislative director, Disabled American Veterans, and the DAV's response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF STEPHEN L. EDMISTON, ASSOCIATE DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 720,000 members of the Disabled American Veterans, I am pleased to appear here today at this oversight hearing to discuss the existing Veterans Administration health care programs and policies which directly impact on the health care needs of America's aging veteran population.

As you know, Mr. Chairman, the DAV membership is composed of honorably discharged veterans who were wounded, injured or otherwise disabled in the wartime service of their country. Therefore, it follows that our organization is primarily concerned with the quality of the VA health care programs and services for all service-connected disabled veterans as set forth in Title 38, United States Code.

Though our organization was founded on the principle that, in terms of veterans' benefits and services, this nation's first obligation rests with the rehabilitation of its service-connected wartime disabled--a principle which envisions high quality hospital and medical care administered by the VA for all service-connected disabled veterans--the DAV is also concerned with the health care programs and services provided by the VA to all other eligible veterans.

At the outset, Mr. Chairman, we believe it is important to note that Americans have acknowledged the moral obligation to care for those disabled in military service even long before our Revolutionary War. From the time the Virginia General Assembly first approved the Indian War Pension Act of 1624 and down to the most recent veterans' bill approved by the 97th Congress, the American people, through their elected representatives, have continually manifested a compassionate concern for the welfare of this nation's veterans and, particularly, those disabled during wartime service.

Veterans' Medical Care Benefits--Historical Review

Mr. Chairman, the only federal benefits provided to America's veterans, up until World War I, were pensions for service-connected disabilities, except, following the Civil War, domiciliary care was provided to some veterans which included only incidental medical treatment.

During World War I, because of the medical problems faced by the millions of returning veterans, the philosophy of providing medical care to veterans changed.

Congress responded to the needs of these returning veterans and enacted legislation (Public Law 90--65th Congress, October 6, 1917) which provided entitlement to medical and hospital services in Public Health Service Hospitals for veterans suffering from wounds or diseases incurred in military service.

This was indeed the beginning of the present day VA health care system for America's veterans.

During the ensuing 65 years, Congress continued to enact legislation broadening the eligibility criteria, as well as the scope of health care services and benefits available to veterans.

On August 9, 1921, Public Law 47, 67th Congress, established the Veterans Bureau. In addition, Public Law 47 also made the facilities of the U. S. Public Health Service, the War Department, the National Homes for Disabled Volunteer Soldiers and such other governmental facilities available for the purpose of providing proper examination, medical care, hospitalization and convalescent care for veterans.

Then, by an Executive Order of April 29, 1922, certain hospitals of the U. S. Public Health Service were transferred to and under the auspices of the Veterans Bureau.

Following this action by the Administration, Congress enacted the following legislation over the next 60 years:

1. Public Law 67-542, March 4, 1923--Extended hospital treatment to veterans of the Spanish American War, Philippine Insurrection and Boxer Rebellion for non-service-connected neuropsychiatric or tuberculosis ailments.

2. Public Law 68-242, June 7, 1924 (World War Veterans Act)--Provided hospitalization to veterans of all wars, occupations and expeditions since 1897, regardless of disability or service-connection.

3. Public Law 71-536, July 3, 1930--Established the Veterans Administration.

4. Public Law 73-2, March 20, 1933 (Economy Act)--Restricted hospitalization to veterans for service-connected disabilities or to wartime veterans for tuberculosis, neuropsychiatric and permanent disabilities.

5. Public Law 73-141, March 28, 1934--Extended hospital treatment to wartime veterans for any nonservice-connected condition if the veteran was unable to defray the cost of care elsewhere.

6. Public Law 78-10, March 17, 1943--Provided hospital and outpatient treatment to World War II veterans on the same basis as veterans of all previous wars.

7. Public Law 81-791, September 19, 1950--Granted outpatient treatment to veterans of the Spanish American War, Boxer Rebellion and Philippine Insurrection.

8. Public Law 82-28, May 11, 1951--Extended hospital and outpatient treatment to Korean veterans on the same basis as veterans of all previous wars.

9. Public Law 86-211, August 29, 1959--Set forth the authority for furnishing invalid lifts when medically indicated to veterans in receipt of nonservice-connected pension benefits.

10. Public Law 86-639, July 12, 1960--Authorized furnishing outpatient medical services for a nonservice-connected disability when reasonably necessary (1) in preparation for an eligible veteran's scheduled hospitalization, and (2) to complete treatment incidental to hospital care.

11. Public Law 87-583, August 14, 1962--Extended hospital and medical care for noncompensable service-connected disabilities of peacetime veterans.

12. Public Law 87-850, October 23, 1962--Provided for the repair or replacement of certain prosthetic or other appliances damaged or destroyed as the result of certain accidents.

13. Public Law 88-450, August 19, 1964--Authorized furnishing unlimited nursing home care in VA facilities and up to six months in private or public nursing homes for patients who had reached maximum hospital benefit but still required a protracted period of nursing home care. The law also authorized ambulatory care, as necessary, for chronic disabilities of any veteran in receipt of increased pension based on need of regular aid and attendance who had received post hospital care for one year for the disability.

14. Public Law 89-385, March 3, 1966--Established eligibility for hospital care for nonservice-connected conditions of veterans with military service after January 31, 1955.

15. Public Law 90-77, August 31, 1967--Extended service-connection, for treatment purposes only, to veterans suffering from an active psychosis which developed within two years from the date of the veteran's discharge from military service.

16. Public Law 90-493, August 19, 1968--Authorized the furnishing of invalid lifts or any type of therapeutic or rehabilitative device or medical equipment and supplies to service-connected veterans or veterans in receipt of nonservice-connected pensions.

17. Public Law 90-612, October 21, 1968--Provided nursing home care in Alaska and Hawaii to veterans who receive hospital care in non-VA facilities.

18. Public Law 91-101, October 30, 1969--Extended community nursing home care, at VA expense, to veterans whose hospitalization was primarily for a service-connected disability, without limitation as to the length of time the care may be provided.

19. Public Law 91-102, October 30, 1969--Established hospital and outpatient care eligibility for any condition of war veterans who were totally and permanently disabled as a result of service-connected disabilities.

20. Public Law 91-500, October 22, 1970--Authorized outpatient treatment for any condition of any veteran in receipt of increased pension or additional compensation based on the need of regular aid and attendance or by reason of being permanently housebound. This law also exempted veterans who were in receipt of pension from making a statement under oath regarding ability to defray necessary expenses of hospital care. Finally, the law authorized hospital care for nonservice-connected disabilities of veterans age 65 or over without regard to their ability to defray expenses of care.

21. Public Law 93-82, August 2, 1973--Permitted outpatient care to any veteran eligible for hospital care when necessary in preparation for or to obviate the need of hospital admission, or to complete hospital care. Outpatient care was also extended to any veteran who had a service-connected disability rated at 80% or more. The law authorized direct admission to community nursing homes for veterans requiring such care for service-connected disabilities and direct admission to VA nursing home care units for nonservice-connected veterans requiring that type of care. The law also provided authority for the treatment of nonservice-connected peacetime veterans, if unable to defray the cost of necessary care elsewhere.

22. Public Law 94-581, October 21, 1976--Redefined medical services to include prosthetic and other similar devices and appliances; authorized mental health services for family members in connection with the treatment of the veteran; established the requirement that service-connected veterans will be afforded priority over other veterans in receiving care at VA health care facilities; provided for the furnishing of home health services, to include home improvements and structural alterations, the cost of which could not exceed $2,500 for service-connected disabilities and $600 for nonservice-connected disabilities; authorized the furnishing of medical services for any disability of a veteran rated 50% or more disabled due to a service-connected disability; established authority for providing intermediate nursing home care; authorized the completion of dental treatment

for a nonservice-connected veteran whose treatment commenced during an episode of inpatient care; and established a 12 month limitation on the period of post hospital care for nonservice-connected patients, except where the Administrator found that a longer period was necessary by virtue of the disability being treated.

23. Public Law 95-588, November 4, 1978--Increased the excess income limit from $500 to $1,000 for those veterans formerly in receipt of aid and attendance or housebound benefits for continuation of their entitlement to drugs and medicines.

24. Public Law 96-22, June 13, 1979--Authorized dental treatment to veterans of World War I, World War II, the Korean Conflict and Vietnam Era who were prisoners of war for not less than six months and to any veteran who had a total service-connected disability. The law also established a readjustment counseling program for Vietnam Era veterans; a pilot program for contracting with halfway houses or similar institutions for the treatment of alcohol or drug dependence or abuse; and authority to furnish contract care for nonservice-connected veterans in receipt of aid and attendance or housebound benefits. Additionally, the law also authorized contracting for diagnostic services from independent outpatient clinics.

25. Public Law 96-151, December 10, 1979--Deleted requirement for annual declaration and certification of inability to pay in connection with nonservice-connected veteran beneficiary travel determinations; expanded authority for contract care in emergencies to any veteran receiving medical services in a VA facility; authorized the furnishing of medical services for any disability of a veteran of the Mexican Border Period or World War I; and placed a $500 annual limitation on contract dental care unless a second opinion certified that the services required are reasonable and necessary.

26. Public Law 96-330, August 26, 1980--Authorized the VA to look behind a nonservice-connected veteran's signed oath of inability to pay for VA medical care.

27. Public Law 96-342, September 8, 1980--Requires that veterans separated on or after September 8, 1980 must complete at least 24 months of their original enlistment in order to be eligible for veterans' benefits, unless the enlistment was terminated due to disability or hardship.

28. Public Law 96-466, October 17, 1980--Provided authority for the Veterans Administration to develop and evaluate a four year pilot program of independent living services for severely disabled service-connected veterans in public or nonprofit community facilities or through facilities operated by the Veterans Administration.

29. Public Law 97-35, August 13, 1981--Restricted outpatient dental treatment to only those veterans who had served a minimum of 180 days on active duty and applied for this benefit within 90 days of discharge.

30. Public Law 97-37, August 14, 1981--Extended eligibility to any former POW for VA hospital and nursing home care and priority VA outpatient treatment for any condition suffered by any former POW.

31. Public Law 97-72, November 3, 1981--Established eligibility for basic health care services directly from the VA for veterans exposed to dioxin or any toxic substance in a defoliant and to those veterans exposed to ionizing radiation from the detonation of a nuclear device; extended the VA's psychological readjustment counseling program for Vietnam veterans for three years; strengthened the VA's authority to recover the cost of health care provided to nonservice-connected veterans who are covered by Worker's Compensation carriers or automobile no-fault insurers, and from states that pay for the costs of victims of personal violence; and requires the VA to operate and maintain a combined total of 90,000 hospital and nursing home beds.

Clearly, Mr. Chairman, the eligibility for and the scope of, VA health care programs and services for this nation's veterans has grown significantly since World War I.

I don't believe we can point to any one particular law and say--This one expanded eligibility and created the VA health care system we have today! Rather, what we have today is an accumulation of efforts by many Congresses--a maturation of a system which over the years was based upon meeting the needs of veterans at that time in history.

Congress is again faced with meeting the needs of veterans--that of aging veterans. While recognizing the fiscal restraint placed upon the Congress as a whole, we believe the needs of the aging veteran population can and will be met.

Demographics of Veteran Population

As you know, Mr. Chairman, there has been any number of different figures toted about with corresponding analyses speculating the aging factor of our veteran population.

While the numbers might vary to some small degree, the analyses are basically the same--the veteran population of this country is rapidly growing older.

We have compiled the following chart from figures recently released by the VA's Office of Reports and Statistics, Statistical Policy and Research Service.

Year	Projected Veteran Population 65 Years & Older	Projected Total Veteran Population
9/30/1982	3,630,300	29,471,700
9/30/1990	7,590,800	28,379,000
9/30/1995	8,782,500	27,302,500
9/30/2000	8,878,800	25,924,900
9/30/2005	8,211,700	24,339,600
9/30/2010	8,051,100	22,701,600
9/30/2015	8,520,300	21,184,300
9/30/2020	7,785,500	19,870,100
9/30/2025	6,911,000	18,762,600
9/30/2030	5,895,500	17,868,400

As you can readily discern, Mr. Chairman, the aged veteran population will rapidly increase within the next ten years. Of course, at the same time, there will be a definite and steady decline in the total number of veterans, barring any major armed conflict.

It is estimated that the veteran population constitutes approximately 45% of all American males over the age of 20 years, and because of the large numbers of veterans of World War II and the Korean Conflict, by 1990 more than half of the U. S. males over age 65 will be veterans, and by 1995 veterans will exceed 60% of the total U. S. male population over 65 years of age. (Note the following table.)

Total Population, Total Males, Total Veterans Over Age 65 Years 1975-2000
(Population in 1,000's)

	1976			1980			1985		
	Pop. 1/	Males 1/	Vet. 2/	Pop.	Males	Vet.	Pop.	Males	Vet.
65-69	8,281	3,662	964	8,700	3,859	1,510	9,244	4,107	2,884
70-74	5,913	2,505	326	6,793	2,853	710	7,301	3,074	1,219
75-79	4,051	1,586	349	4,324	1,698	186	5,108	1,991	514
80-84	2,724	982	511	2,816	989	299	3,064	1,075	116
85+	1,966	629	128	2,294	709	255	2,588	766	231
	22,935	9,364	2,278	24,927	10,108	2,960	27,305	11,013	4,964

	1990			1995			2000		
	Pop.	Males	Vet.	Pop.	Males	Vet.	Pop.	Males	Vet.
65-69	10,022	4,471	3,586	9,791	4,402	2,819	9,192	4,152	2,181
70-74	7,782	3,281	2,295	8,433	3,572	2,857	8,244	3,521	2,251
75-79	5,501	2,148	873	5,885	2,301	1,651	6,394	2,509	2,059
80-84	3,639	1,264	316	3,939	1,368	540	4,236	1,472	1,027
85+	2,881	836	118	3,352	959	176	3,756	1,062	303
	29,825	12,000	7,188	31,400	12,602	8,043	31,822	12,716	7,821

1/ Department Commerce Population Estimates and Projections, 1977
2/ Office of Controller, VA, September 1, 1977

It is quite clear that the veteran is and will continue to be a significant factor of the aging male population of the United States throughout the remainder of this century and well into the next century.

While this Committee, as evidenced by this oversight hearing, has an interest and concern for the health care needs of the aging veteran population, figures from the U. S. Bureau of Census reveal the need for the entire Congress to address the needs of the aging American population in general. (Note the following table.)

Persons 65 and Over
Incidence in the Population
1900-2040
(In 1,000's)

	Number	Percent
1900.....	3,099	4.1%
1930.....	6,705	5.4
1960.....	16,675	9.2
1977.....	23,431	10.8
1990.....	29,824	12.7
2000.....	31,822	12.9
2010.....	34,837	13.9
2020.....	45,102	17.8
2030.....	55,024	22.1
2040.....	54,925	22.8

Source: U.S. Bureau of the Census. Current Population Reports, Series P-23, No. 59 and Series P-25, No. 704. (Series III)

The most recent President's Commission on Pension Policy reached the following conclusion in one of their working papers on the "demographic shifts and projections--the implications for pension systems."

> Between now and the year 2035, the number of people 65 and over may increase by more than 120% and the estimated number of disabled beneficiaries is likely to increase more than 35% because of demographic factors alone. These increases however are not as important as the fact that the potential labor force from ages 18-64, which will have to support the retired and disabled, is estimated to be only 6% larger in 2035 than it is today. It is the relative difference in the growth of the aged and the potential labor force that is of most concern for the pension system.
>
> Historically, there has been an implicit social contract that the working generations help support the retired and disabled generations either privately or publicly. But the contract may have to be renegotiated if the future size of the retired and disabled more than doubles relative to the size of the working age generation. Therefore, the basic challenge that the demographic statistics discussed in this paper pose is how the society will prepare for the future retirement of increasingly large generations and how soon the preparations for their retirement will begin.

While the conclusion reached by the President's Commission on Pension Policy addresses a different area of concern, an analogy can be drawn between planning and providing adequate retirement incomes for the aged and adequate VA health care benefits for aged veterans.

Quite frankly, Mr. Chairman, we must ask ourselves--has the nation truly addressed the needs of its aging population? I believe the answer to that question is clearly no.

While the VA is probably further ahead in planning for the care of aged veterans than is the rest of the nation, in terms of planning the retirement security of all aged Americans, the time is drawing near when the Congress must address what role our VA health care system will play in dealing with the health care needs of aging veterans and, indeed, possibly aging America.

VA Extended Care Program

As you know, Mr. Chairman, the VA's Extended Care Program consists of long-term care programs in VA nursing home care, community nursing home care, domiciliary care, state home care (nursing home, domiciliary and hospital), hospital based home care, residential care and geriatric research, education and clinical centers.

The VA Nursing Home Care Program is designed to provide skilled nursing care and related medical services, as well as, social and recreational activities. Typically, nursing home patients require a prolonged period of nursing and rehabilitation supervision in an effort to attain and maintain optimal function.

By the end of Fiscal Year 1980 the VA had a total of 8,496 operating nursing home care beds in 92 VA medical centers. During that Fiscal Year, 12,750 veterans were treated with an average daily census of 7,933 patients.

Of the patients treated, more than 61% were 65 years or older, while the average age of all veterans treated was 69.7 years.

Approximately 66% of the VA nursing home care patients were in receipt of either VA compensation benefits (26%) or nonservice-connected pension benefits (40%).

VA nursing home care beds nearly doubled from approximately 4,500 in Fiscal Year 1971 to 8,496 in Fiscal Year 1980.

Like the VA Nursing Home Care Program, the Community Nursing Home Care Program has grown steadily since Fiscal Year 1971, from just over 3,000 patients as an average daily census to more than 8,500 in Fiscal Year 1980.

As you know, Mr. Chairman, veterans requiring nursing home care for a service-connected condition may be placed, at VA expense, in a community nursing home for as long as nursing care is required, while nonservice-connected veterans can only receive this care, at VA expense, for a period not to exceed six months.

During Fiscal Year 1980 more than 28,500 veterans were treated in approximately 2,900 community nursing homes in all 50 states and Puerto Rico. Of this number, 47% were in receipt of VA disability compensation and 28% were receiving nonservice-connected pension benefits.

While the average age of veterans treated in community nursing homes was 67 years, only 56% were 65 years of age or older.

The VA's Domiciliary Care Program provides medical and other professional care for eligible ambulatory veterans who are disabled by age, disease or injury and who are in need of care, but do not require hospitalization or skilled nursing home care.

Unlike the VA's other extended care programs, the Domiciliary Care Program has had a declining daily patient census of 12,000 in Fiscal Year 1971 to just under 8,000 in Fiscal Year 1980.

Veterans cared for in this VA program tend to be younger, with an average age of 59 in Fiscal Year 1980 and only 30% of those treated were 65 years of age or older.

Approximately 71% of those who received VA domiciliary care in Fiscal Year 1980 were in receipt of either VA compensation (27%) or nonservice-connected pension (44%) benefits.

The State Veterans Homes furnish domiciliary, nursing home or hospital care in state facilities to veterans eligible for VA care. The VA's relationship to State Veterans Homes is based on two grant programs--one is a per diem program which enables the VA to assist the state in providing care to eligible veterans and the other provides assistance with the funding of construction, remodeling or alteration of State Veterans Facilities.

Generally, veterans treated in State Veterans Nursing Home and Domiciliaries tend to be older than those in VA facilities with a greater proportion of veterans being 65 years of age or older.

While, during Fiscal Year 1980, State Veterans Homes maintained an average daily patient census of 5,586 nursing home, 4,892 domiciliary and 929 hospital patients, they can only supplement, rather than substitute for other VA extended care programs due to the limited facilities available nationwide.

Hospital Based Home Care, the newest VA extended care program, provides chronically ill veterans with health care services within the confines of the veteran's home. A hospital based treatment team provides medical, nursing, social, dietetic and rehabilitation regimens, as well as training for family members regarding care of the veteran.

As of Fiscal Year 1980, 30 VA medical centers were capable of providing home health services to veterans and during that Fiscal Year 157,000 home visits were made by VA medical personnel to treat 5,454 patients.

There is no doubt that the VA's Hospital Based Home Care Program improves the quality of life and care of the veteran. Furthermore, it has also proven to be significantly cost-effective as compared to VA nursing home, community nursing home and VA hospital care.

The VA's Residential Care Program provides care to veterans in private homes selected by the VA at the veteran's own expense.

This program is designed to provide care to veterans who do not require hospital or nursing home care, but who, because of health problems, are not able to resume independent living and have no suitable family resources to provide the needed care.

Each veteran in this program is provided room, board, personal care and general heath care supervision, as well as monthly follow-up visits by VA social workers and medical care personnel, and remain outpatients of the nearest VA hospital.

VA Geriatric Research, Education and Clinical Centers consist of eight Centers which serve to attract and develop superior staff in the field of gerontology and geriatrics by utilizing and redirecting resources for geriatric care in an effort to advance and integrate research and educational achievement in geriatrics and gerontology into the VA health care system.

The VA has been authorized to designate up to 15 health care facilities as GRECCs but, Congress has withheld funding more than the eight Centers currently in operation until such time as the existing Centers can establish their potential for which they were originally created.

There is no doubt that geriatric research and education conducted by the VA today can only lead to better modalities of care for the aging veteran population, as well as older Americans in general.

Therefore, it becomes paramount for the Congress to fully fund, and the VA to properly and effectively implement, the GRECC Program so that the VA health care system will then have the necessary tools to meet the needs of our aging population.

* * * *

Mr. Chairman, upon reviewing the extent of the health care programs and benefits which have been provided veterans, there is no doubt that the American people support health care programs for those who served in the military service of this country.

However, this Committee and indeed, the entire Congress is facing an inevitable showdown within the very near future. As you know, this country will have an extremely large aged veteran population which, by reason of age alone, will require more episodes of acute hospital care and longer periods of chronic extended care.

Given the present constraints within which funding and facilities have been made available to provide health care benefits to veterans by the VA, the size and needs of a rapidly aging veteran population and the eligibility for VA health care, it is quite evident that the Congress must decide, and decide soon, the role the VA health care system will play in dealing with this fast approaching situation.

Quite frankly, Mr. Chairman, dealing with the health care needs of aging veterans is synonymous with dealing with the health care of all older Americans. In the past 40 years the VA has been a leader in the medical community, as evidenced by the many contributions it has made through medical research, medical administration and patient care which has directly and indirectly benefited all Americans.

Should not the VA again be in the forefront of improving the health care of all aging Americans? Mr. Chairman, we believe this question must be answered in the affirmative so that veterans, the VA, the medical community and the entire country can move forward to respond to the health care needs of older veterans and, indeed, our entire aged citizenry. Quite frankly, we cannot expect those in the private medical sector to meet the needs of our aging population unless someone, like the VA, takes the leadership role.

That concludes my statement, Mr. Chairman. The DAV wishes to thank you and the members of this Committee for providing us this opportunity to present our views on this most important subject.

RESPONSE OF THE DISABLED AMERICAN VETERANS TO THE WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. In your personal opinion, what direction should the VA health-care system take during the next few decades, in order to balance the health-care needs of all veterans and respond effectively to the changing needs of millions of new elderly eligible veterans?

Answer 1. The DAV strongly supports a VA Health Care System that is capable of providing a wide variety of health care services -- to include hospital, ambulatory, and extended care for all eligible veterans. Certainly there is no doubt, as evidenced by the testimony of many witnesses at the June 30, 1982 hearing, that this country will have an extremely large aged veteran population within the next decade. In order for the VA to respond effectively to meet the needs of this rapidly aging veteran population the DAV believes it is essential that the VA assume a leadership role in geriatric health care with an eye towards the development and implementation of similar programs in other federal agencies and the private medical community. This could be accomplished by either expanding the current GRECC Program or establishing a new pilot program of geriatric health care.

Question 2. Please comment on the need and the ability of the VA to utilize the so-called "case management" model, which would coordinate VA health-care and other benefits with community-based organization services for the aged.

Answer 2. Given the VA's present funding and facilities it is quite evident the VA will never be able to totally care for and meet the needs of all aged veterans. Therefore, in the absence of an ongoing program within the VA to provide the total services needed by aged veterans, it then becomes imperative for the VA to develop programs to coordinate services with community-based groups and organizations to meet these veterans' needs.

Question 3. What barriers do you believe exist in the VA health-care system which may prevent the "de-institutionalization" of its aging population?

Answer 3. Quite frankly, the DAV does not believe barriers exist within the VA Health Care System which prevent the "de-institutionalization" of its aged patients. Those aged veterans who are receiving extended health care from the Veterans Administration are obviously in need of the care and, in reality have no alternative source of care as compared to the cost effective care being provided by the VA.

Chairman SIMPSON. Mr. Currier, please.

Mr. CURRIER. Good afternoon, Mr. Chairman. Thank you for the opportunity to present AMVETS' views on the VA health-care system as it relates to the aging veterans' population of America.

With an ever burgeoning population of aging veterans of World War II and the Korean conflict whose numbers are now approaching the 13 million mark and who represent a high percentage of those individuals of America at or above the age 65, AMVETS is of the opinion that the Veterans' Administration health-care system must rapidly gear itself to the present and future needs of this group.

In doing so it must, of necessity, take into consideration the population shifts which periodically occur, a prime example of which, of course, is the tendency of veterans as they age to move to the warmer climates, such as the Sun Belt.

This is not to say, however, that focus should be drawn away from those veterans who choose not to migrate to warmer climates for there will always be that group who stay near their home.

With increased technology the tendency has been for the length of stay as an inpatient in VA hospitals to go down as certain conditions become easily treated on an outpatient basis.

With this in mind, AMVETS is of the opinion that to meet the needs of the aging veteran both now and in the future there needs to be attention focused on enlarging and improving the outpatients' facilities of the Veterans' Administration.

We'd like to cite the situation which now exists in Florida whereby non-service-connected veterans are, for the most part, turned away from VA medical care facilities due to the inability of those facilities to cope with the surge of veterans seeking treatment.

Also in Florida, Mr. Chairman, veterans are faced with long lines and uncomfortable waits at VA medical centers due to the numbers of veterans seeking care.

This we feel is due to a certain lack of foresight in the late 1950's and early 1960's as to trends of the aging veterans. Had the VA been able to foresee such a large number of retirees, then perhaps such a situation might not exist today.

To avoid a continuation of this and future other such situations, we would strongly encourage the members of this committee, as well as the VA, to begin the project of enlargement and follow through with new construction of outpatient care facilities.

The VA over the years has been a leader in medical research and development as relates to acute care and we feel that no less can be expected of the health care system as it relates to the long term needs of veterans.

AMVETS feels that geriatric care must be high on the priority list of the VA health-care system as relates to research and development.

Mr. Chairman, we are aware that many people are, fearful of an increased burden on the Veterans' Administration system. However, we would point out to the members of the committee that income plays a large measure in determining just who applies for VA health care.

Among the population of males age 20 or older there are proportionately fewer veterans than nonveterans with incomes of less than $10,000 and proportionately more with higher incomes than $10,000 a year.

Statistically the VA has determined that the practice of veterans when choosing health-care facilities is directly related to income as those with the ability to pay for private care will normally choose to do so and those without will choose the Veterans' Administration for assistance.

Mr. Chairman, in closing we wish to emphasize to the members of the committee that as the veterans age their needs will change and increase. We feel that VA has the mechanism to do the proper research and development in these areas to continue to improve their programs.

For this reason, AMVETS hopes that the VA exercise of the options available to it to preserve and improve upon the present capabilities in veterans' health care.

Mr. Brinsky, the national service and legislative director for AMVETS, has testified many times before this committee expressing the concerns of AMVETS that the VA is not moving fast enough to meet the needs of an aging veterans' population and we wish to reiterate those views.

There is ample provision in existing legislation to allow the VA to do so and yet they seem to hesitate.

It is our hope that you, Mr. Chairman, and the members of this committee will act diligently to preserve and improve the capabilities of the VA to deal effectively with the needs of the aging veteran population.

The VA has extended itself into the area of geriatric care to some extent and will, with support and urging, continue to play an important role in this area.

The veterans of America, as they age, need to know that there is a health-care system which is in tune with their needs and receptive to their application.

AMVETS feels there needs to be a focus on those needs and appreciates this and any future opportunity to comment.

Mr. Chairman, thank you again for the opportunity to comment on the health-care system relating to the aging veteran.

This concludes my testimony.

Chairman SIMPSON. I thank you very much and I thank all of the representatives.

[The prepared statement of Peter B. Currier, deputy national service and legislative director, American Veterans of World War II, Korea, and Vietnam, and AMVETS' response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF PETER B. CURRIER, DEPUTY NATIONAL SERVICE AND LEGISLATIVE DIRECTOR, AMERICAN VETERANS OF WORLD WAR II, KOREA, AND VIET NAM (AMVETS)

Good morning, Mr. Chairman, and thank you for the opportunity to present AMVETS views on the VA health care system as it relates to the aging veteran population of America. With an ever burgeoning population of aging veterans of World War II and the Korean Conflict, whose numbers are now approaching the 13 million mark and who represent a high percentage of those individuals in America at or above age 65, AMVETS is of the opinion that the Veterans Administration health care system must rapidly gear itself to the present and future needs of this group. In doing so it must of necessity take into consideration the population shifts which periodically occur. A prime example of which is the tendency of veterans as they age to move to warmer climates such as the sun belt. This is not to say, however, that focus should be drawn away from those veterans who choose not to migrate to warmer climates for there will always be individuals who will stay near their home.

With increased technology, the tendency has been for the length of stay as an inpatient in VA hospitals to go down as conditions become easily treated on an outpatient basis. With this in mind, AMVETS is of the opinion that to meet the needs of the aging veteran, both now and in the future, there needs to be attentions focused on enlarging and improving the Veterans Administration outpatients facility. As prime example, we would like to sight the situation which now exists in Florida whereby nonservice connected veterans are, for the most part, turned away from VA medical care facilities due to the inability of those facilities to cope with the surge of veterans seeking treatment. Also, in Florida, veterans are faced with long lines and uncomfortable waits at VA Medical Centers due to the number of veterans seeking care. This we feel is due to a lack of foresight in the late fifties, early sixties as to the trends of aging veterans. Had the Veterans Administration been able to foresee such a large number of retirees, then perhaps such an undesirable situation might not exist today. To avoid a continuation of this and future other such situations from occurring we would strongly encourage the members of this Committee as well as the Veterans Administration to begin the project of enlargement and new construction of outpatient care facilities.

The Veterans Administration, over the years, has been a leader in medical research and development as relates to acute care, and we feel that no less can be expected of the VA health caie system as relates to the long term needs of the veterans. AMVETS feels that geruatruc care must be high on the priority list of the VA health care system as relates to research and development. The VA health care system is a viable alternative to private health care when considering both quality and cost factors.

While being treated in a private facility, the aging veteran through his insurance plan and/or medicare is paying for care at an inflated rate since medical care facilities are no less intent on making a profit and any other business today. If treated at the

Veterans Administration health care facility nearest him, then the veteran is receiving quality long term care which is not based upon a profit making goal. Indeed, in many instances the veterans health needs in a private enterprise are clouded somewhat by a desire to turn a profit. As an example, we would cite the case of an individual whose situation was brought to our attention. This elderly gentleman, a World War I veteran service connected as a result of lung damage due to mustard gas, was involved in a head-on collision. The emergency team transported him to the nearest medical center for treatment whereupon the doctors were duly notified of his status as a 100% disabled veteran eligible for care at the local Veterans Administration hospital. The Veterans Administration facility was notified and it was determined that, until in a stable condition, the veteran could not be transferred to the VA. Over the course of the next few days, the veteran repeatedly made his wishes known that he was desirous of going to the Veterans Administration hospital, however, the doctors at the local hospital chose to keep him there until discharge. When the hospital was questioned as to how his care was to be paid for, its response was that medicare would pay for the care of the veteran. When it was pointed out to the veterans medicare would only pay 80%, the hospital responded by saying they would in turn bill the veteran for the remaining 20%. It was then pointed out that the veteran's care could have been facilitated at no charge to the veteran at the nearest VA hospital and that this matter would be of interest to the medicare system, the hospital stated that it would not bill the veteran. Mr. Chairman, we must wonder aloud whether or not this takes place at other hospitals in other situations relating to other veterans. We have to feel that such a situation does exist and that these veterans fall through the cracks of the system and are unfairly billed for care that could have been received at VA medical centers. In this manner, we feel that private health care facilities may be taking advantage of not only the system but the veterans themselves. Many times these private health care facilities will submit bills to medicare which are then reviewed by medicare officials for proper fees. We feel this is a very good system, however, when a certain fee is judged to be too high, medicare will pay the portion it deems feasible and then the veteran is billed by the hospital for any unpaid portion. At a fixed income these bills can be a great burden to the aging veteran. The same health care could be received at a lower cost to the entire system at a Veterans Administration health care facility and without undue psychological trauma to the veteran.

Mr. Chairman, this is but one example of why AMVETS feels that a greater emphasis on geriatric care must be maintained in the VA hospital system. As a system which is primarily concerned with the needs of a special group of individuals who have special needs themselves, the VA is the logical choice for the veteran to look to for care and for the medical community to look to for leadership in the area of geriatric research.

Mr. Chairman, we are aware that many people are fearful of an increased burden on the Veterans Administration system, however, we would point out to the members of the Committee that income plays a large measure in determining just who applies for VA health care. Among the population of males, age 20 years or older, there are proportionately fewer veterans than nonveterans with family incomes of less than $10 thousand and proportionately more with higher income. Statistically, the Veterans Administration has determined that the practice of veterans, when choosing health care facilities, is directly related to income as those with the capabilities to pay for private care will normally choose to do so. Those without income capabilities to pay for private care will look to the Veterans Administration for assistance. This tendency lends itself dramatically to those veterans who are now and in the future will be on fixed incomes. The projection to the year 2005 the number of veterans 65 or older indicater that through the years 1990, the age group 65 years of age or older will increase at an accelerated rate until they peak at the figure of 8,229,000. By the same year, veterans age 65 to 74 will increase to 5,978,000. As these veterans fall into a fixed income bracket, they will require health care at a low cost and AMVETS feels this means Veterans Administration care. The tendencies of the veterans population to age is directly equated with increases in the intensity of care over the past decade and, perhaps, can be projected over the next two decades as well. Since 1970, the area of cardiac catheterization, open-heart surgery, and dialysis have increased rapidly as the population ages. Also increasing is the number of days spent by a patient in intensive care. These are brought as examples to underscore the need for continued research and development in the area of geriatric care to meet the needs previously mentioned as well as those which may arise in the future of the aging veteran.

Mr. Chairman, in closing we wish to emphasize to the members of this Committee that as the veteran ages, his needs will change and increase. We feel the Veterans Administration has the mechanism to do the proper research and development in these areas and only lacks legislation to continue and improve their programs. For this reason, AMVETS would be totally supportive of any legislation which would be geared to improving the geriatric care capabilities of the Veterans Administration and would welcome the opportunity to present its views on any such legislation proposed. It is our hope that you, Mr. Chairman, and the members of this Committee will act diligently to preserve and improve the capabilities of the Veterans Administration health care system to deal effectively with the needs of the aging veteran population. The Veterans Administration has extended itself into the area of geriatric care and will, with support, continue to play an important role in this area. The veterans of America, as they age, need to know that there is a health care system which is in tune with their needs and is receptive to their application for care. AMVETS feels that there needs to be a focus on those needs and appreciates this and any future opportunity to comment.

Mr. Chairman, thank you again for the opportunity to comment on the health care system as relates to the aging veteran and this concludes our testimony.

RESPONSE OF THE AMERICAN VETERANS OF WORLD WAR II, KOREA, AND VIET NAM (AMVETS) TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS AFFAIRS

Question 1. In your personal opinion, what direction should the VA health-care system take during the next few decades, in order to balance the health-care needs of all veterans and respond effectively to the changing needs of millions of new elderly eligible veterans?

Answer 1. It is our personal opinion that the Veterans Administration must, during the next few decades, reexamine its outpatient care facilities in an effort to accommodate the ever burgeoning population of elderly veterans. Since modern technology in many areas is resulting in shorter inpatient stays and at the same time giving the capability to treat certain conditions on an outpatient basis which previously would require care as an inpatient, we feel that the current capabilities to treat outpatients must be necessarily improved and expanded. We also are of the personal opinion that greater focus needs to be centered on geriatrics and, in particular, an accelerated research into the causes and treatment of Alzheimer's disease. There is a particular need, we feel, for the Veterans Administration to expand its nursing care facilities to accommodate this aging veterans population in the future.

Question 2. Please comment on the need and the ability of the VA to utilize the so-called "case management" model, which would coordinate VA health-care and other benefits with community-based organization services for the aged.

Answer 2. As to the need and the ability of the Veterans Administration to utilize the "case management" model to coordinate VA health-care and other benefits with community-based organization services for the aged, we feel that the affiliations with medical schools lends itself nicely to coordination of health-care for veterans in the community. We are not in favor of divorcing from the VA health-care system the nonservice-connected veteran since we feel that although their disabilities may be nonservice-connected, these veterans by their experiences in the service have special needs which can only be addressed by the Veterans Administration. At present the Social Services Office of the Veterans Administration maintains contact in the community with CBOs to monitor programs which can assist the veteran outside of the VA system. While there is room for improvement, we do feel that such a program working concomitant to the medical care provided by the Veterans Administration is basically a sound system.

Question 3. What barriers do you believe exist in the VA health-care system which may prevent the "de-institutionalization" of its aging population?

Answer 3. As to barriers which presently exist in the health-care system of the Veterans Administration, which possibly prevent the de-institutionalization of the aging veterans population, we feel, as previously mentioned, that increased research in the areas of Alzheimer's disease may result in a certain de-institutionalization of these veterans. Recent private research has indicated that there may be a cure for this disability which previously was thought to be simply a result of the process of aging. If, in fact, this is true, then by accelerating this research to the point where a cure may be discovered will in itself lead to removing many chronic care elderly veterans from the system.

Question 4. Would you comment on the effectiveness of the present role of the VA GRECCs in the agency's overall program of providing health care to eligible veterans? Please address each of the three program areas of geriatric care, i.e., research, education, and clinical activities.

Answer 4. I believe the aforementioned comments address the issue of the VA GRECCs in the agency's overall program of providing health care to eligible veterans. Much is to be learned in the area of geriatric care, and the Veterans Administration has the present mechanism to provide this knowledge. Its research program is specifically veteran oriented and, as such, is in a position to provide insight into the needs of its constituency. We do feel that greater emphasis on research in the geriatric care area needs to be made. It also is necessary that as research provides new knowledge that the present mechanisms and avenues of education as well as new areas be invoked. We would encourage the Veterans Administration to share its knowledge with all private care facilities. Critical activities as relates to outpatient care must be stepped up as new technologies provide the ability to treat disabilities previously considered as requiring long stays as inpatients on an outpatient basis. Prime examples of the results of a combination of new technology and poor planning are evident in several areas--most notably in Florida where almost before completion the outpatient care facilities in Miami were outmoded. Mr. Chairman, it is frustrating to stand in any type of line awaiting care, however, when it relates to a medical problem, which in and of itself is uncomfortable, to wait in a line is even more discouraging. For this reason, we would hope that the Veterans Administration will move expediently to expand its outpatient care facilities to accommodate this population.

Question 5. Many people have stated recently that VA resources should be transferred to correspond with geographic population movements to the sunbelt areas. Please comment on Dr. Custis' statement that the decreased veteran population in the northeast areas will not result in a corresponding decreased demand there for VA health-care services.

Answer 5. As to Dr. Custis' statement that a decreased veterans population in northeast areas will not result in a corresponding decreased demand there for health-care services, we feel that if one considers the fact that the veterans population is aging at a faster rate than it is moving and that also more individuals will choose to stay in a given area than will choose to move, then it becomes evident that the need for care will remain somewhat static in the northeast areas. Although there appears to be a shift of the aging veterans population in northeast areas to sunbelt regions, it is also a truism to state that many younger veterans who are in search of employment and places to settle comfortably are moving between the states in the northeast. For example, in the northeast there are several states which actually are seeing an increase in their veterans population as economics force them to seek out job and housing opportunities. Also to be considered is the fact that as the issue of veterans population becomes more proclaimed, some veterans in an effort to avoid any so-called crush of people will be discouraged from a move. There also is to be considered a certain amount of parochialism whereby a veteran chooses to stay near his family.

Chairman SIMPSON. I just have a comment, Don, to you.

This is not a cost savings measure that we're discussing today. I think that's important to keep in context that we have a problem. How do we best adapt? How do we best respond to it?

Certainly, there is no attempt to relegate large numbers of veterans to welfare beneficiaries as your statement says. You and I both know that we're both prone to correcting each other from time to time, and that's good. I like that.

But I think it's important to realize and to keep in context that we have a Veterans' Administration budget of some $25 billion, and that there has been a ninefold increase since 1950 from $855 million to $8.3 billion in health-care expenditures.

We've had a veterans population that has remained constant in those past 10 years at about 30 million. While that remained constant, overall hospital and medical care expenditures have risen 277 percent, from $3 billion to $8.3 billion.

So, you know, that's the stuff I get used to in this game; but it makes it more difficult.

Mr. SCHWAB. Mr. Chairman, we're not——

Chairman SIMPSON. Yes. Now you may have your rebuttal in just 1 minute. I always give you that opportunity.

I think you want to also be aware that in this latest budget resolution, which was anguishing enough, I can assure you—there ain't no fun in it; I'm listed as 0 to 8 with every known constituent group in the United States just by sticking with the basic budget—that in this process the VA will receive about a $685 million increase over fiscal year 1982.

I would just kind of like to draw the cue ball back on the table every once in a while and get the correct english on it.

Now, it's your shot.

Mr. SCHWAB. Yes, sir. Thank you.

What I was trying to bring out in my testimony is that we believe there are sufficient alternative methods for health care for the immediate future and down the road quite a few years if they were funded, but they have not been funded.

With respect to the VA budget, we differ on this considerably because the VA budget in outlays at $23.8 billion is 3.09 percent of the Federal budget; the least it's been in 10 years.

In that 10-year period the Federal budget has tripled. The VA budget has doubled. Somebody is getting the increased money. It's not the veterans. It hasn't been national defense until this budget.

We just need to increase the proportion of the Federal budget for veterans if we're going to give them the care that we believe Congress has envisioned and mandated over the years.

And I thank you.

Mr. LYNCH. Mr. Chairman, I'd like to associate The American Legion if I may with at least that part of Mr. Schwab's remarks that relate to the fact that while the cost of veterans' programs has increased the percentage of Federal funds expended on veterans over the past 10 years has declined from 5 percent during the middle of the Vietnam war to down to 3.2 percent for fiscal 1982.

Chairman SIMPSON. Well, these are why we have such spirited discussions in the Veterans' Affairs Committee with the national veterans groups.

I understand that. I like it. I don't thrive on confrontation, but I never tried to hide from it. But it is important to realize, one thing and that is that the American veteran is not being tossed out of his bed on the floor of the VA hospital and not being cared for.

Mr. LYNGH. We never said that, sir.

Chairman SIMPSON. Every time I see, and I continue to address it this way, something which is part of the ancient game of Washington which is either one of the twin engines of emotionalism or guilt—add the third one, racism; that's how the system seems to function sometimes—you either pass legislation or defeat it on those three engines of guilt, emotionalism, or racism.

I always try to clean that stuff out of the game and deal with things up front, put it out there; and I'm going to continue to do that knowing full well, as I say, that the house payments are still being made in Cody, Wyo. and I can always repair there.

I thank you very much for your testimony and always for your interest; and it is very creative and you're very important parts of this. I mean that very sincerely.

Mr. LYNGH. We appreciate that.

Mr. SCHWAB. Thank you, sir.

Chairman SIMPSON. Thank you.

I think Senator Thurmond had a statement. There may be additional statements by other members of the committee. Those will be inserted in the record.

With that I thank you all very much for coming here and for your testimony; and that concludes the hearing.

[Whereupon at 12:16 p.m., the hearing was concluded.]

[The following prepared statements and letters were received by the committee for the hearing record:]

PREPARED STATEMENT OF JEROME STONE, PRESIDENT OF THE ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION

Mr. Chairman and members of the Committee -

I am President of the Alzheimer's Disease and Related Disorders Association (ADRDA), a national organization with 52 member chapters, operating in conjunction with some 250 family support groups.

First of all, I want to thank you for affording us the opportunity to present our views concerning the aging veteran population.

As you are well aware, the average age of the veteran population will increase significantly over the next two decades. Presently, 10 percent of the veteran population is age 65 or over; this will increase to more than 30 percent by the year 2000. Viewed from a slightly different perspective, by 1990 more than half of all males over age 65 will be veterans. Of course, all of this will place considerable strain on the VA's existing medical care system -- unless we begin immediately to deal with this issue.

One aspect of the issue which I would like to address relates to care and treatment of veterans with Alzheimer's disease.

By way of background, Alzheimer's disease is responsible for the majority of cases of senile dementia in the U.S. Currently, more than 1.5 million people are striken with the disease -- and not all of them are elderly. In fact, more than 60,000 people in their 40's and 50's have been diagnosed as having Alzheimer's disease.

Alzheimer's disease is a neurological disorder which often renders its victims totally incapable of caring for themselves. Because the victim requires around-the-clock care and attention, many families are forced to turn to nursing homes for help. Last year, more than half of the nursing home admissions were persons suffering from Alzheimer's disease. VA nursing homes are experiencing about the same rate of admissions of Alzheimer's patients -- which brings me to a very serious problem involving the VA's apparent lack of a consistent policy toward veterans suffering with Alzheimer's disease.

Hilda Pridgeon, an ADRDA Board member and a pioneer in this field, has devoted considerable time and effort toward helping veterans and their families through the difficult stages of the disease. She has found that while some Alzheimer's patients have been admitted to VA facilities, others have been turned away. Furthermore, she has learned that some Alzheimer's patients are being asked to leave after only a few weeks' stay. This, of course, permits hardly enough time to evaluate the patient, let alone establish a useful therapy program.

Mr. Chairman, neither Medicare nor private insurance plans cover Alzheimer's disease. This fact, coupled with the VA's actions only serves to jeopardize the patient and put even greater financial and emotional strains on families. As it stands now, the VA's failure to care for some has the effect of forcing spouses to the point of destitution before they can obtain help.

It is not our intention, Mr. Chairman, to convey the idea that the VA has purposely set out to ignore its responsibilities. The fact is that some veterans with Alzheimer's disease are being treated -- and treated quite well. For my part, I believe the VA hospital system generally offers top-notch care. The problem is that there seems to be no national policy regarding Alzheimer's patients.

Our hope is that your Committee will help us in our efforts to encourage the VA to implement a fair and equitable admissions policy throughout the nation.

Furthermore, ADRDA urges that more work be done in the way of geriatric research. The VA's GRECC program should be permitted to expand to the fullest. With that expansion should come a greater emphasis on improving the care and treatment afforded veterans with Alzheimer's disease.

Thank you, Mr. Chairman.

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PREPARED STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY ON EYE CARE NEEDS OF THE AGING VETERAN

The American Academy of Ophthalmology, a national professional medical organization representing 12,000 physicians who are trained in the specialty of ophthalmology (diagnosis and treatment of problems of the eyes and vision), appreciates the opportunity to comment on eye care needs of the aging veteran. The Academy, which is dedicated to helping the public maintain healthy eyes and good vision, wishes to emphasize the critical importance of planning for a comprehensive eye care service that will meet the health care needs of the aging veteran.

In a recent monograph, the VA Department of Medicine and Surgery outlined the impact that treating a higher proportion of older veterans will have on the VA health care delivery system. According to this report, disease rates will "increase with age and account for the higher utilization rates among older veterans. With an older patient population, the VA can expect increased workloads in certain areas and decreased workloads in others." (IL-10C-81-2, 11/17/81, page A-3). Of great significance, the VA projects that the number of inpatient discharges for ophthalmic-related diagnosis will increase by a dramatic 74% by the year 2000, as compared to 1980 levels. As a result, ophthalmic inpatient services will be second only to gerontologic services in terms of increased demand.

To gain some perspective on the magnitude of the 74% increase, it may be helpful to look at some current statistics. In FY 1980, inpatient discharges for veterans whose principal or associated diagnosis related to a disease or condition of the eye, excluding blindness, totaled 36,385. Of these, 19,607 were ophthalmic surgical procedures performed on veterans. The average age of these veterans was 63.1 years.

In addition to inpatient services, outpatient eye care services also must be considered. With increased utilization of techniques that can be safely performed in an ambulatory setting as well as preventive and follow-up services, there is likely to be an increased demand for outpatient eye care services. In 1980, 215,420 veterans, the average age of whom was 59.8, made outpatient visits to ophthalmology clinics. Of these veterans, 92,999 were service-connected.

With the aging of the veteran population, there is likely to be an increase in the problems and diseases of the eye associated with the aging process. Currently the major eye disorders that affect the elderly are:

- cataract: a clouding of the lens that can be treated by surgically removing the natural lens and replacing it with eyeglasses, a contact lens, or an implanted intraocular lens.
- glaucoma: an increase of pressure in the eyeball that is a major cause of blindness.
- macular degeneration: a loss of central vision caused by a breakdown of the retina.
- diabetic retinopathy: a loss of vision caused by hemorrhagging of the tiny blood vessels in the eye.

All of these eye disorders are serious. If not diagnosed and treated early, they can lead to loss of vision and thus inhibit an individual's ability to work and remain independent. Only an ophthalmologist can treat these disorders and diseases. An ophthalmologist is a medical doctor who is educated, trained, and licensed to provide total care of the eye. This care includes performing comprehensive eye examinations, prescribing corrective lenses, diagnosing diseases and disorders of the eye, and carrying out the medical and surgical procedures necessary for their treatment.

To ensure that the eye care needs of the aging veteran population will be met, it will be necessary to estimate future needs. The Academy believes that the critical first step is to study the status of eye care currently provided by the VA. Such a study would not cost in excess of $40,000.

Unfortunately, although data on the current characteristics and activities of the VA inpatient services exist, there is a dearth of data on the VA outpatient delivery system. For the purposes of planning and meeting the needs of the older veterans, a sound and accurate data base covering both inpatient and outpatient eye care services is critical.

Although there have been studies of the VA health care system, none of them have provided comprehensive information on existing eye care services, manpower, facilities, equipment, and demand. A 1977 National Academy of Sciences review analyzed VA physicians, patients, and services in such broad categories that it was impossible to distinguish the number of ophthalmologists or ophthalmic patients and the types of ophthalmic services existing in the VA health care system. Similarly, an assessment of the role of optometry in the VA conducted in 1978 by the General Accounting Office based its analysis on a review of pertinent literature and discussions with optometrists. Actual demand and an assessment of total current eye care services being provided were not examined.

The American Academy of Ophthalmology, therefore, urges Congress to authorize a government funded, private study of existing eye care services, manpower, facilities, equipment, and demand in the VA. Such a study will provide the data needed to plan adequately for a comprehensive eye care service that will meet the needs of the aging veteran.

In addition, to ensure that veterans receive the best quality eye care, the Academy recommends to Congress the establishment of a single unified eye service in the Veterans Administration at both the Central Office and the health care facility levels. Under the current system, ophthalmology is included in the Surgical Service. Such inclusion does not recognize the fact that ophthalmology is a medical specialty as well as a surgical specialty, nor that many ophthalmic services are provided on an outpatient basis. In addition, a separate, independent optometry service exists in the VA. Since it represents only one facet of eye care, duplication of some services and clinical facilities occurs.

A unified eye service would be most cost effective and efficient. Evidence of this can be seen in similar models in both the federal and private sectors. Many health maintenance organizations are organized with some form of a unified eye service. In addition, the Uniformed Armed Services have a unified eye service under the direction of an ophthalmologist. A copy of the Academy's official policy statement on this issue is appended to this testimony and we ask that it be included in the record.

In conclusion, the American Academy of Ophthalmology believes that to meet the eye care needs of the aging veteran, a comprehensive assessment of existing eye care services must be conducted and unified eye services within the VA must be established.

POLICY STATEMENT

AMERICAN ACADEMY OF
OPHTHALMOLOGY

THE ROLE OF OPHTHALMOLOGY

Policy:

All evaluations which claim to diagnose eye disease should be carried out by or under the direct supervision of a physician. An ophthalmologist is a physician with specialized medical knowledge of the visual system.

Background:

Ophthalmology, the branch of medical science concerned with the structure, functions and diseases of the eye and visual system, dates from antiquity. As a science and art, ophthalmology has often been on the leading edge of progress in medicine. Some of the oldest effective therapeutic agents were used to combat eye disease, and operation for cataract was one of the earliest procedures. For over a century a thorough understanding of optics, refraction and binocular vision have been recognized as crucial to the practice of ophthalmology and, indeed, the original scientific studies illuminating these subjects were all made by ophthalmologists. The American Board of Ophthalmology was the first specialty board in the United States, pioneering the way for what has become the accepted method of certifying postgraduate specialty training in medicine throughout the world. Thus, not only has ophthalmology always been a part of medicine, it has also been one of its most progressive specialties.

The practice of ophthalmology has historically encompassed all aspects of visual function in health and disease including refraction, orthoptics, binocular vision and strabismus as well as medical and surgical treatment of disease involving the visual system.

The general practice of ophthalmology is predominantly a medical specialty, consisting of medical eye examinations and optical and medical therapy of ocular visual abnormalities. The average ophthalmologist examines 100 patients per week and performs 50 refractions.

Evaluation:

For the ultimate benefit of the American public, a clear distinction should be made between a diagnostic vision examination and an examination for purposes of refraction. A diagnostic vision examination involves the practice of medicine and requires the highly specialized training of a physician.

A refractive examination involves the taking of measurements of the visual system which is simply a data gathering procedure and involves no medical expertise.

The utilization of ancillary personnel to perform certain nonmedical procedures or tests is appropriate as a means of enhancing the productivity of ophthalmologists and thereby increasing the availability of ophthalmologists to provide medical services and to provide the highest level of comprehensive vision care to the greatest number of individuals. The ophthalmologist is and should remain as the provider with the primary and ultimate responsibility for the delivery of comprehensive and continuing medical eye care including vision services to the American public.

Developed by: Committee for Health Manpower,
Secretariat for Governmental Relations

Approved: Board of Directors, 10/14/80

POLICY STATEMENT

AMERICAN ACADEMY OF
OPHTHALMOLOGY

EYE CARE IN THE VETERANS ADMINISTRATION

Policy:

The American Academy of Ophthalmology supports the concept of a unified eye service in the Veterans Administration at both the Central Office and health care facility levels.

Background:

Such unified eye care models are cost effective and efficient and exist in the federal and private sectors. Within these models non-medical personnel report to the Chief of Ophthalmology. An example of this at the federal level is the Uniformed Armed Services.

At the private provider level, examples include the majority of health maintenance organizations (HMO). There are generally two formats for eye care delivery within such HMOs. In some, such as the Kaiser-Permanente Health Plans and Group Health Association of Washington, D.C., there are separate departments of Ophthalmology and Optometry with the Chief of Optometry reporting to the Chief of Ophthalmology for the coordination of eye care policy. In others such as the Group Health Plan of St. Paul, Minnesota and the Harvard Community Health Plan, there is a single eye department under the direction of a Chief of Ophthalmology.

Evaluation:

Such a unified service would include both medical and non-medical health care providers, and would be coordinated by a Physician Director, Eye Service, in Central Office. Ophthalmologists, optometrists, opticians, and auxiliary personnel, such as technicians and technologists, would be included.

At the health care facility level, both ophthalmologists and optometrists would be professionally and administratively supervised by a Physician Coordinator of Eye Care.

In those facilities where there is an ophthalmologist, this coordinator should be an ophthalmologist. In those facilities without an ophthalmologist the coordinator should be a designated physician.

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Pursuant to V.A. Circular 10-81-33 (Treatment and care of eye patients), "The responsibility for the overall treatment of each patient lies with a physician who coordinates the treatment and care rendered by various physicians, non-physician specialists and support staff... In accord with defined privileges, optometrists may render care to patients with ocular disease under the supervision and with approval of an ophthalmologist or the primary designated physician."

A single eye care service would assure the best quality care. It would be the most cost efficient means of accomplishing the above stated policy (10-81-33), and would avoid multiplicity of similar services and clinic facilities.

Developed by: Secretariat for Governmental Relations

Approved by: Board of Directors, 10/3/81

GLOSSARY

OPTICIAN:	An optician is a technician who makes, verifies and delivers lenses, frames and other specially fabricated optical devices and/or contact lenses upon prescription to the intended wearer. The optician's functions include: prescription analysis and interpretation; determination of the lens forms best suited to the wearer's needs; the preparation and delivery of work orders for the grinding of lenses and the fabrication of eye wear; the verification of the finished ophthalmic products; the adjustment, replacement, repair and reproduction of previously prepared ophthalmic lenses, frames and other specially fabricated ophthalmic devices.
OPTOMETRIST:	An optometrist, while not attending medical school, is a health service provider who is involved with vision problems. Optometrists are specifically educated, trained and state licensed to examine the eyes and to determine the presence of vision problems. Optometrists determine visual acuity and prescribe spectacles, contact lenses and exercises. Optometrists are qualified to perform all services listed above under opticians.
OPHTHALMOLOGIST:	An ophthalmologist is a physician (doctor of medicine or doctor of osteopathy) who specializes in the comprehensive care of the eyes and visual system. The ophthalmologist is the only practitioner medically trained and qualified to diagnose and treat all eye and visual system problems. Each is licensed by a state to practice medicine and surgery. Thus, an ophthalmologist is the only provider who can deliver total eye care (i.e., "vision services", contact lenses, medical eye care, and surgical eye care) as well as diagnose general diseases of the body. The ophthalmologist has completed four years of college pre-medical training, four years or more of medical school, one year of internship and three or more years of specialized medical training and experience in eye care.
REFRACTION:	Refraction is measurement of the optical state of the eye.
VISION SERVICES:	Vision services are refractive and optical services delivered by ophthalmologists, optometrists and opticians. These services include an examination of the eye for corrective lenses and the supplying and dispensing of glasses and contact lenses if required.
VISION CARE:	Vision care is a term commonly used to describe vision services when provided as part of insurance and other third party payment programs.

TOTAL EYE CARE:	Total eye care refers to vision, medical and surgical eye services provided by an ophthalmologist. Included as an integral part of total or comprehensive eye care are refractive and optical services.
APHAKIA:	Aphakia is the absence of the lens of the eye, usually resulting from surgery to remove cataracts.

Approved: Board of Directors
American Academy of Ophthalmology
6/26/81

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June 25, 1982

The Honorable Alan K. Simpson
Chairman, Committee on Veterans'
Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Simpson:

Thank you very much for your inquiry of June 17, 1982 concerning issues related to the aging veteran population in the Veterans Administration Health-care System. I very much regret that I am not able to personally participate in this important hearing which you are conducting on the 30th of June.

However, I would like to take this opportunity to share with you only two major recommendations which I think go to the heart of the issue of the aging veteran in the VA system. I am speaking here from the point of view of someone who has been a part of the VA system, having served as Chief of Psychiatry of the Tampa VA Medical Center and also as Chief of the Section of Geriatric Psychiatry in the Tampa VA and also as someone who currently serves as a Director of the Suncoast Gerontology Center for Health and Long Term Care, a regional resource on issues of health, aging and long-term care, in a non-VA setting. In my opinion two major actions on the part of the VA would be highly responsive to the actual needs of the client population of elderly veterans in the United States.

The first of these would be a major shift of resources from their deployment for inpatient hospital medical and psychiatric care, almost exclusively, to a far more balanced distribution of the same resources to include some inpatient hospital care but a substantial amount of community based care, including ambulatory care, home delivered services, outpatient services, and day-care services which are specifically responsible to the changing circumstances of aging veterans in the Unites States. The

Association of Long Term Care Gerontology Centers, Inc., an organization of the nine currently existing operational long term care gerontology centers, all of whom are funded by grants from the Department of HHS, all are recognizing the broader scope of long term and geriatric services which are required by our aging population. We know that these needs are not confined only to hospital care, although hospital care of course must remain a part of such a system.

My second recommendation relates specifically to wishing to see a substantial number of additional Geriatric Research Education and Clinical Centers (GRECC's) to be developed by the VA in the very near future. These centers have done much to focus on the actual needs of geriatric patients in those facilities where they are available within the VA system. They have focused interests, enthusiasm, resources, and above all, new techniques, on the aging veteran. The creation of some additional ten to fifteen GRECC's throughout the Unites States, within the VA system would be highly desirable and beneficial to the needs of the aging veteran. We particularly feel very keenly the need for such a GRECC in the southeastern United States to which area many aging veterans have been migrating, thus creating disproportionate demands for services in states like Florida and other coastal states as compared to a number of northern states.

If only these two actions were to be vigorously pursued by the Congress, I think we would see substantial improvements in the quality as well as quantity of services available to aging veterans.

In my opinion unavailability of community based services and the unavailability of specialized geriatric inpatient services such as are available in the GRECC evaluation units, often leads to more prolonged and more expensive inpatient hospitalizations for such veterans because the intermediate steps which might address their problems, both before and after an acute care episode, are simply not available.

I very much value your efforts, Senator, in focusing on this critically important issue in our nations health-care system. If I can be of any further assistance to you and your committee please do not hesitate to call on me.

Sincerely yours,

Eric Pfeiffer, M.D.
Director, Suncoast Gerontology Center
and
President, Association of Long Term
Care Gerontology Centers, Inc.

EP/brc